Health Care General Committee

Wednesday, November 9, 2005
10:45 AM – 11:45 AM
306 HOB

COMMITTEE MEETING PACKET

Revised

Allan G. Bense
Speaker

Gayle B. Harrell
Chair

AGENDA
Health Care General Committee
November 9, 2005
10:45 a.m. – 11:45 a.m.
306 HOB

I. Call to order/Roll Call

II. Opening Remarks

III. Consideration of the following bills:

- HB 67--Automated External Defibrillator Devices by Sobel
- HB 93 -- Automated External Defibrillators by Henriquez
- HB 111 -- Defibrillators in State Parks by Anderson

IV. Presentation on Avian Flu – H5N1

V. Presentation on Electronic Health Records

VI. Closing Remarks and Adjournment

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 67 Automated External Defibrillator Devices
SPONSOR(S): Sobel
TIED BILLS: **IDEN./SIM. BILLS:** SB 252

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care General Committee		Ciccone	Brown-Barrios
2) Governmental Operations Committee			
3) Health Care Appropriations Committee			
4) Health & Families Council			
5)			

SUMMARY ANALYSIS

An Automatic External Defibrillator (AED) is a small, lightweight device used to assess a person's heart rhythm, and, if necessary, administer an electric shock to restore a normal rhythm in victims of sudden cardiac arrest. AEDs are designed to be used by people without medical backgrounds, such as police, firefighters, flight attendants, security guards, and lay rescuers.

Currently, the Florida Department of Health is authorized to dispense funds contained in the Emergency Medical Services Trust Fund to local agencies and emergency services organizations to improve and expand prehospital emergency medical services in the state. There are two primary ways money can be dispensed; by an individual board of county commissioners, as it deems appropriate, or by the Department of Health for making the matching grants to local agencies, municipalities and emergency medical services organizations. The bill will allow *youth athletic organizations* to receive funds from board of county commissioners and to allow *youth athletic organizations* to participate in the grant program. The bill specifies that *youth athletic organizations* that work in conjunction with local emergency medical services organizations may apply for grants for the purpose of expanding the use of automatic external defibrillators in the community.

HB 67 defines a *youth athletic organization* as a private not-for-private organization that promotes and provides organized athletic activities to youth. The bill also provides a cross reference to the definition of automated external defibrillators found in the statutes.[1]

HB 67 authorizes the Department of Health to annually dispense funds contained in the Emergency Medical Services Trust Fund to emergency medical services organizations and *youth athletic organizations*, and revises dispensing of such funds to include youth athletic organizations.

HB 67 requires the Department of Health to implement an educational campaign to inform any person who acquires an automated external defibrillator device that the liability immunity under s. 768.1325, Florida Statutes, is contingent upon proper equipment maintenance, testing and user training.

Depending on the method of communication, a minimal fiscal impact may be incurred by the Department of Health to implement the educational campaign required in the bill.

The effective date of this bill is July 1, 2006.

[1] S. 768.1325(2) (b), F.S.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provides Limited Government – HB 67 will grant county commission boards greater access to funds contained in the Emergency Medical Service Trust Fund, and the ability to distribute those funds to emergency medical service organizations and to youth athletic organizations, as they deem appropriate.

B. EFFECT OF PROPOSED CHANGES:

Currently, s. 401.111, Florida Statues, authorizes the Department of Health to dispense funds contained in the Emergency Medical Services Trust Fund through a grant application process to local agencies and emergency services organizations. These grants should be designed to assist agencies and organizations in providing emergency medical services, including emergency medical dispatch. There are two primary ways that money can be dispensed from the trust fund: 1) by an individual board of county commissioners to emergency medical services organizations, as it deems appropriate or 2) by the Department of Health for making matching grants to local agencies, municipalities and emergency medical services organizations for the purpose of conducting research, increasing existing levels of emergency medical services evaluation, community education, injury prevention programs, and training in cardiopulmonary resuscitation and other lifesaving and first aid techniques. The bill amends s. 401.111, Florida Statutes, to expand the list of participants who may participate in the Emergency Services Grant Program and who may apply for or receive monies from the Emergency Medical Services Trust Fund to include *youth athletic organizations*.

The bill allows *youth athletic organizations* that work in conjunction with local emergency medical services organizations to apply for grants for the purpose of expanding the use of automatic external defibrillators in the community.

The bill directs the Department of Health to implement an educational campaign to inform any person who acquires an automated external defibrillator device that his or her immunity from liability under s. 768.1325, F. S., for harm resulting from the use or attempted use of the device, does not apply if he or she fails to properly maintain and test the device or provide appropriate training in the use of the device.

Background

Chapter 401, Florida Statutes, specifies that it is the legislative intent that emergency medical services are essential to the health and well-being of all citizens and that private and public expenditures for adequate emergency medical services represent a constructive and essential investment in the future of the state and our democratic society. A major impediment to the provision of adequate and economic emergency medical services to all citizens in the inability of governmental and private agencies with a service area to respond cooperatively to finance the systematic provision of such services.

Emergency Medical Services Grant Program

The Emergency Medical Services Grant Program was established to assist governmental and private agencies within a service area to respond cooperatively to finance the systematic provision of emergency medical services to all citizens.

The Department of Health (DOH) is authorized to dispense grant monies from the Emergency Medical Services Trust Fund according to the distribution formula provided in section 401.113(a) and (b), Florida Statutes, as follows:

(a) Forty-five percent of the monies collected by the DOH must be divided among the counties according to the proportion of the combined amount deposited in the trust fund from the county. An individual board of county commissioners may distribute these funds to emergency medical service organizations within the county, as it deems appropriate.

(b) Forty percent of the monies collected by DOH are for making matching grants to local agencies, municipalities, and emergency medical services organizations for the purpose of conducting research, increasing existing levels of emergency medical services evaluation, community education, injury prevention programs, and training in cardiopulmonary resuscitation and other lifesaving and first aid techniques.

HB 67 provides that grant monies may be distributed by the board of county commissioners as it deems appropriate to emergency medical service organizations and youth athletic organizations within the county.

According to DOH staff, grant applications are thoroughly reviewed. The DOH receives the majority of applications for automated external defibrillators form licensed emergency medical service providers for purchase and distribution to agencies and organizations in their service areas that have a significant number of cardiac related responses. Grant applications are reviewed and scored by a panel of EMS providers. Applications that receive a favorable score are provided funds to purchase the equipment.

Automated external Defibrillators

According to a number of articles in *The Physician and Sportsmedicine* there is increased interest to provide access to automatic external defibrillators at national local sporting events. Specifically, an article written by Dr. Aaron Rubin, *The Physician and Sportsmedicine, Vol 28 No.3, March 2000,* reads: "Although sudden cardiac death is rare in sports, having an automated external defibrillator (AED) available facilitates early defibrillation and increases the chance of survival for an athlete in cardiac arrest. In sudden cardiac arrest, the most frequent initial rhythm is ventricular fibrillation (VF). The only effective treatment for VF is electrical defibrillation and the probability of success declines rapidly over time. Chances of resuscitation decrease 7 percent to 10 percent each minute." Earlier articles in the same publication: *Automatic External Defibrillators in the Sports Arena: The Right Place, The Right Time, Vol, 26 No 12, December 1998*, support the benefits of having an AED accessible to athletes during sporting events. "In large sports settings, AEDs can supplement standby EMS services. At sports events in small towns or venues, the AED may be the only means available to effect early defibrillation."

C. SECTION DIRECTORY:

Section 1. Adds s. 401.107(6) and (7), F.S., providing the definition of *youth athletic organization* and the cross reference to the definition of *automatic external defibrillator* in s. 768.1325(2) (b), F.S.

Section 2. Amends s. 401.111, F.S., to include youth athletic organization as an eligible participant in the emergency medical services grant program, clarifies that the grant monies are designed to assist youth athletic organizations that work in conjunction with local emergency medical services organizations, to expand the use of automatic external defibrillators in the community.

Section 3. Amends s. 401.113(a) and (b), F.S., to direct the Department of Health to annually dispense funds contained in the Emergency Medical Services Trust Fund as it deems appropriate to emergency medical service organizations and *youth athletic organizations*.

Section 4. Requires the Department of Health to implement an educational campaign to inform any person who acquires an automated external defibrillator device that the liability immunity under s. 768.1325, Florida Statutes, is contingent upon proper equipment maintenance, testing and training.

Section 5. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None

2. Expenditures:

   The Department of Health is uncertain as to cost to the department to implement the educational campaign outlined in the bill. A minimal cost would be incurred if the department were to use the state's website to provide the information regarding equipment maintenance, testing and user training.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None

2. Expenditures:

   HB 67 increases the number of entities authorized to participate in the Emergency Medical Services Grant Program.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Youth athletic organizations would be eligible for grant funds to purchase automatic external defibrillators. Allowing youth athletic organizations to apply for a grant to procure an automated external defibrillator may stimulate private sector revenue sources. It is undetermined how many such organizations would receive county funds or grant monies.

D. FISCAL COMMENTS:

See above.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable because this bill does not appear to: require counties or municipalities to spend funds or to take actions requiring the expenditure of funds; reduce the authority that cities or counties have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with cities or counties.

2. Other:

   None

B. RULE-MAKING AUTHORITY:

The Department of Health has sufficient rulemaking authority to implement the requirements of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

A bill to be entitled

An act relating to automated external defibrillator devices; amending s. 401.107, F.S.; defining the terms "youth athletic organization" and "automated external defibrillator device"; amending s. 401.111, F.S.; providing for grants to youth athletic organizations for automated external defibrillator devices; amending s. 401.113, F.S.; providing for disbursement of funds from the Emergency Medical Services Trust Fund; requiring the Department of Health to implement an educational campaign to inform the public about the lack of immunity from liability regarding the use of automated external defibrillator devices under certain conditions; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsections (6) and (7) are added to section 401.107, Florida Statutes, to read:

401.107 Definitions.--As used in this part, the term:

(6) "Youth athletic organization" means a private not-for-profit organization that promotes and provides organized athletic activities to youth.

(7) "Automated external defibrillator device" means a device as defined in s. 768.1325(2)(b).

Section 2. Section 401.111, Florida Statutes, is amended to read:

401.111 Emergency medical services grant program;

authority.--The department is hereby authorized to make grants to local agencies, ~~and~~ emergency medical services organizations, and youth athletic organizations in accordance with any agreement entered into pursuant to this part. These grants shall be designed to assist local ~~said~~ agencies and emergency medical services organizations in providing emergency medical services, including emergency medical dispatch, and to assist youth athletic organizations that work in conjunction with local emergency medical services organizations to expand the use of automated external defibrillator devices in the community. The cost of administering this program shall be paid by the department from funds appropriated to it.

Section 3. Paragraphs (a) and (b) of subsection (2) of section 401.113, Florida Statutes, are amended to read:

401.113 Department; powers and duties.--

(2) The department shall annually dispense funds contained in the Emergency Medical Services Trust Fund as follows:

(a) Forty-five percent of such moneys must be divided among the counties according to the proportion of the combined amount deposited in the trust fund from the county. These funds may not be used to match grant funds as identified in paragraph (b). An individual board of county commissioners may distribute these funds to emergency medical services ~~service~~ organizations and youth athletic organizations within the county, as it deems appropriate.

(b) Forty percent of such moneys must be used by the department for making matching grants to local agencies, municipalities, ~~and~~ emergency medical services organizations,

and youth athletic organizations for the purpose of conducting research, increasing existing levels of emergency medical services, evaluation, community education, injury-prevention programs, and training in cardiopulmonary resuscitation and other lifesaving and first aid techniques.

1. At least 90 percent of these moneys must be made available on a cash matching basis. A grant made under this subparagraph must be contingent upon the recipient providing a cash sum equal to 25 percent of the total department-approved grant amount.

2. No more than 10 percent of these moneys must be made available to rural emergency medical services, and notwithstanding the restrictions specified in subsection (1), these moneys may be used for improvement, expansion, or continuation of services provided. A grant made under this subparagraph must be contingent upon the recipient providing a cash sum equal to no more than 10 percent of the total department-approved grant amount.

The department shall develop procedures and standards for grant disbursement under this paragraph based on the need for emergency medical services, the requirements of the population to be served, and the objectives of the state emergency medical services plan.

Section 4. The Department of Health shall implement an educational campaign to inform any person who acquires an automated external defibrillator device that his or her immunity from liability under s. 768.1325, Florida Statutes, for harm

resulting from the use or attempted use of the device, does not apply if he or she fails to:

(1) Properly maintain and test the device; or

(2) Provide appropriate training in the use of the device to his or her employee or agent when the employee or agent was the person who used the device on the victim, except as provided in s. 768.1325, Florida Statutes.

Section 5. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 93 Automated External Defibrillators
SPONSOR(S): Henriquez
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care General Committee		Ciccone	Brown-Barrios
2) Criminal Justice Committee			
3) Health Care Appropriations Committee			
4) Health & Families Council			
5)			

SUMMARY ANALYSIS

An Automatic External Defibrillator (AED) is a small, lightweight device used to assess a person's heart rhythm, and, if necessary, administer an electric shock to restore a normal rhythm in victims of sudden cardiac arrest. AEDs are designed to be used by people without medical backgrounds, such as police, firefighters, flight attendants, security guards, and lay rescuers.

HB 93 defines the terms automated external defibrillator and defibrillation. HB 93 also creates misdemeanor offenses related to abuse and tampering with AEDs and violation of local ordinances regarding AEDs.

HB 93 requires the Department of Health to implement an educational campaign to inform any person who acquires an automated external defibrillator device that the liability immunity under s. 768.1435, Florida Statutes, is contingent upon proper equipment maintenance, testing and user training.

Depending on the method of communication, a minimal fiscal impact may be incurred by the Department of Health to implement the educational campaign required in the bill.

The effective date of this bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Promote personal responsibility – This bill creates criminal penalties for wrongful conduct.

B. EFFECT OF PROPOSED CHANGES:

Section 401.2915, F.S., provides that an Automated External Defibrillator (AED) may be used by any person for the purpose of saving the life of another person in cardiac arrest. Users of an AED must successfully complete an appropriate training course in CPR, or a basic first aid course that includes CPR, and must demonstrate proficiency in the use of an AED. In addition, any person or entity in possession of an AED is encouraged to register the device with the local EMS medical director, and any person who uses an AED is required to activate the EMS system as soon as possible. The bill clarifies that certain use, misuse or otherwise tampering of an automated external defibrillator constitutes a first degree misdemeanor. This bill also authorizes local governments to adopt an ordinance to require a person to obtain a license, permit or inspection certificate for AEDs. Finally, the bill requires the Department of Health to implement an education campaign to inform persons who use an AED that immunity from liability does not extend to failure to properly maintain and test the AED or failure to provide appropriate training in the use of an AED.

This additional education, training and licensing requirements in the bill are designed to increase the likelihood of proper use and an improved registry of AEDs used in Florida.

Cardiac Arrest:

The American Heart Association (AHA) describes a cardiac arrest as:

> Cardiac arrest is the sudden, abrupt loss of heart function. It is also called sudden cardiac arrest or unexpected cardiac arrest. Sudden death (also called sudden cardiac death) occurs within minutes after symptoms appear. The most common underlying reason for patients to die suddenly from cardiac arrest is coronary heart disease. Most cardiac arrests that lead to sudden death occur when the electrical impulses in the diseased heart become rapid (ventricular tachycardia) or chaotic (ventricular fibrillation) or both. This irregular heart rhythm (arrhythmia) causes the heart to suddenly stop beating.

According to the AHA, brain death and permanent death start to occur within 4 to 6 minutes after someone experiences cardiac arrest. Cardiac arrest can be reversed if it is treated within a few minutes with an electric shock to the heart to restore a normal heartbeat—a process called defibrillation. The AHA states that a victim's chances of survival are reduced by 7 to 10 percent with every passing minute without defibrillation, and few attempts at resuscitation succeed after 10 minutes.

An AED is an electronic device that can shock a person's heart back into rhythm when he or she is having a cardiac arrest. The AHA estimates that more than 95 percent of cardiac arrest victims die before reaching the hospital. In cases where defibrillation is provided within 5 to 7 minutes, the survival rate from sudden cardiac arrest can be up to 49 percent.

Section 401.2915, F.S., provides the minimum requirements for an individual who intends to use an AED in cases of cardiac arrest, as follows:

- A person must obtain appropriate training, to include completion of a course in cardiopulmonary resuscitation or successful completion of a basic first aid course that includes cardiopulmonary

resuscitation training, and demonstrated proficiency in the use of an automated external defibrillator;
- A person or entity in possession of an automated external defibrillator is encouraged to register with the local emergency medical services medical director the existence and location of the automated external defibrillator; and
- A person who uses an automated external defibrillator is required to activate the emergency medical services system as soon as possible upon use of the automated external defibrillator.

1990 Legislation

In 1990, based on the development of AED technology and in an effort to reduce the death rate associated with sudden cardiac arrest, the Legislature enacted s. 401.291, F. S. This law broadened the list of persons authorized to use an AED to include "first responders." First responders included police officers, firefighters and citizens who are trained as part of locally coordinated emergency medical service response teams. At that time, to use an AED, a first responder had to meet specific training requirements, including;

- Certification in CPR.
  Or—
- Successful completion of an eight hour basic first aid course that included CPR training.
- Demonstrated proficiency in the use of an automatic or semiautomatic defibrillator.
- Successful completion of at least six hours of training, in at least two sessions, in the use of an AED.

At the time, the creation of s. 401.291, F.S., was intended to increase the availability of automatic external defibrillators and thereby reduce the death rate from sudden cardiac arrest in Florida. It is undocumented as to whether the intended effect was ever achieved; however the law was repealed on October 1, 1992.

Deregulating AED

Chapter 97-34, Laws of Florida, repealed s. 401.291, F.S., thereby deregulating the use of an AED. The bill created s. 401.2915, F.S. (see above).

Tort Liability

Section 768.1325, F.S., the Cardiac Arrest Survival Act, provides immunity from liability for a person who uses or attempts to use an automated external defibrillator device in a perceived medical emergency. Under s. 768.1325(2) (b), F.S., "automated external defibrillation" device is defined as a defibrillator device that:

- Is commercially distributed in accordance with the Federal Food, Drug, and Cosmetic Act;
- Is capable of recognizing the presence or absence of ventricular fibrillation, and is capable of determining without intervention by the user of the device whether defibrillation should be performed; and
- Upon determining that defibrillation should be performed, is able to deliver an electrical shock to an individual.

Effect of Bill

This bill amends s. 401.2915, F.S., to define the term automated external defibrillator as a lifesaving device that:

- Is commercially distributed as a defibrillation device in accordance with the Federal Food, Drug, and Cosmetic Act;

- Is capable of recognizing the presence or absence of ventricular fibrillation and is capable of determining, without intervention by the use of the device, if defibrillation should be performed; and
- Is capable of delivering an electrical shock to an individual, upon determining that defibrillation should be performed.

This definition conforms to the definition in s. 768.1325(2) (b), F.S.

The bill also defines defibrillation as the administration of a controlled electrical charge to the heart to restore a viable cardiac rhythm.

The bill provides it is a first degree misdemeanor for any person who intentionally or willfully:

- Tampers with or otherwise renders an automated external defibrillator inoperative except during such time as the automated external defibrillator is being serviced, tested, repaired, or recharged, except pursuant to court order.
- Obliterates the serial number on an automated external defibrillator for purposes of falsifying service records.

A first degree misdemeanor is punishable by up to one year in jail and a fine of up to $1,000.

The bill also provides that a local ordinance may require a person to obtain a license, permit, or inspection certificate regarding AEDs. Enforcement by the municipality may be as provided in s. 162.22, F.S. The ordinance may provide that it is an infraction or a criminal offense for any person to intentionally or willfully:

- Fails to properly service, recharge, repair, test, or inspect an automated external defibrillator.
- Uses the license, permit or inspection certificate of another person.
- Holds a permit or inspection certificate and allow another person to use said permit or inspection certificate number.
- Uses, or permits the use of, any license, permit or inspection certificate by any individual or organization other than the one to whom the license, permit or inspection certificate is issued.

Section 162.22, F.S., allows a municipality to impose penalties for violation of a municipal ordinance. Unless otherwise provided for in law, punishment for violation of a municipal ordinance may not exceed 60 days in jail and a $500 fine (equivalent to a second degree misdemeanor).

The bill directs the Department of Health to implement an educational campaign to inform any person who acquires an automated external defibrillator device that his or her immunity from liability under s. 768.1325, F. S., for harm resulting from the use or attempted use of the device, does not apply if he or she fails to properly maintain and test the device or provide appropriate training in the use of the device.

C. SECTION DIRECTORY:

Section 1. Amends s. 401.2915, F.S., to define terms and provide criminal penalties.

Section 2. Requires the Department of Health to implement an educational campaign to inform any person who acquires an automated external defibrillator device that the liability immunity under s. 768.1325, Florida Statutes, is contingent upon proper equipment maintenance, testing and user training.

Section 3. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None

2. Expenditures:

   The Department of Health is uncertain as to cost to the department to implement the educational campaign outlined in the bill. A minimal cost would be incurred if the department were to use the state's website to provide information regarding equipment maintenance, testing and user training.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None

2. Expenditures:

   None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

   None

D. FISCAL COMMENTS:

   See above.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable because this bill does not appear to: require counties or municipalities to spend funds or to take actions requiring the expenditure of funds; reduce the authority that cities or counties have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with cities or counties.

2. Other:

B. RULE-MAKING AUTHORITY:

The Department of Health has sufficient rulemaking authority to implement this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

A bill to be entitled

An act relating to automated external defibrillators; amending s. 401.2915, F.S.; revising legislative intent with respect to the use of an automated external defibrillator; defining an automated external defibrillator as a lifesaving defibrillation device; defining a related term; providing that it is a first degree misdemeanor for a person to commit certain acts involving the misuse of an automated external defibrillator; authorizing a local government to adopt an ordinance to license, permit, or inspect automated external defibrillators; providing for enforcement of such local ordinances; requiring the Department of Health to implement an educational campaign to inform the public about the lack of immunity from liability regarding the use of automated external defibrillators under certain conditions; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 401.2915, Florida Statutes, is amended to read:

401.2915 Automated external defibrillators.--It is the intent of the Legislature that an automated external defibrillator may be used by any person for the purpose of saving the life of another person in cardiac arrest. In order to achieve that goal, the Legislature intends to encourage training in lifesaving first aid, set standards for the use of automated

external defibrillators, and encourage their use.

(1) As used in this section, the term:

(a) "Automated external defibrillator" means a lifesaving defibrillation device that:

1. Is commercially distributed as a defibrillation device in accordance with the Federal Food, Drug, and Cosmetic Act.

2. Is capable of recognizing the presence or absence of ventricular fibrillation and is capable of determining, without intervention by the user of the device, if defibrillation should be performed.

3. Is capable of delivering an electrical shock to an individual, upon determining that defibrillation should be performed.

(b) "Defibrillation" means the administration of a controlled electrical charge to the heart to restore a viable cardiac rhythm.

(2) In order to ensure public health and safety:

(a) ~~(1)~~ All persons who use an automated external defibrillator must obtain appropriate training, to include completion of a course in cardiopulmonary resuscitation or successful completion of a basic first aid course that includes cardiopulmonary resuscitation training, and demonstrated proficiency in the use of an automated external defibrillator.

(b) ~~(2)~~ Any person or entity in possession of an automated external defibrillator is encouraged to register with the local emergency medical services medical director the existence and location of the automated external defibrillator.

(c) ~~(3)~~ Any person who uses an automated external defibrillator shall activate the emergency medical services system as soon as possible upon use of the automated external defibrillator.

(3) Any person who intentionally or willfully:

(a) Tampers with or otherwise renders an automated external defibrillator inoperative, except during such time as the automated external defibrillator is being serviced, tested, repaired, or recharged or except pursuant to court order; or

(b) Obliterates the serial number on an automated external defibrillator for purposes of falsifying service records,

commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(4) A local ordinance may require a person to obtain a license, permit, or inspection certificate for an automated external defibrillator. Such ordinance may provide for any enforcement method authorized by s. 162.22. The ordinance may provide that it is an infraction or a criminal offense for any person to intentionally or willfully:

(a) Fail to properly service, recharge, repair, test, or inspect an automated external defibrillator;

(b) Use the license, permit, or inspection certificate of another person to service, recharge, repair, test, or inspect an automated external defibrillator;

(c) Hold a permit or inspection certificate and allow another person to use that permit or inspection certificate number to service, recharge, repair, test, or inspect an

automated external defibrillator; or

(d) Use or permit the use of any license, permit, or inspection certificate by any individual or organization other than the one to whom the license, permit, or inspection certificate is issued to service, recharge, repair, test, or inspect an automated external defibrillator.

(5)~~(4)~~ Each local and state law enforcement vehicle may carry an automated external defibrillator.

Section 2. The Department of Health shall implement an educational campaign to inform any person who acquires an automated external defibrillator device that his or her immunity from liability under s. 768.1325, Florida Statutes, for harm resulting from the use or attempted use of the device, does not apply if he or she fails to:

(1) Properly maintain and test the device; or

(2) Provide appropriate training in the use of the device to his or her employee or agent when the employee or agent was the person who used the device on the victim, except as provided in s. 768.1325, Florida Statutes.

Section 3. This act shall take effect July 1, 2006.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 01(for drafter's use only)

Bill No. **HB 93**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health Care General

Representative(s) Harrell offered the following:

Amendment

Remove line(s) 31 and 32 and insert:

(a) "Automated external defibrillator" means a device as defined in 768.1325(2)b).

========== T I T L E A M E N D M E N T ==========

Remove line(s) 6 and insert:

defibrillator;

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 111 Defibrillators in State Parks
SPONSOR(S): Anderson
TIED BILLS: **IDEN./SIM. BILLS:** SB 274

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care General Committee		Ciccone	Brown-Barrios
2) Agriculture & Environment Appropriations Committee			
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

An Automatic External Defibrillator (AED) is a small, lightweight device used to assess a person's heart rhythm, and, if necessary, administrator an electric shock to restore a normal rhythm in victims of sudden cardiac arrest. AEDs are designed to be used by people without medical backgrounds, such as police, firefighters, flight attendants, security guards, and lay rescuers.

House Bill 111 creates s. 258.0165, F.S., to encourage each state park to have a functioning automated external defibrillator (AED) at all times.

This bill appropriates $92,000 from the General Revenue Fund to the Division of Recreation and Parks, Department of Environmental Protection. The appropriated funds are to be used to purchase as many AEDs as possible

The bill provides an effective date of July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

This bill does not address any of the House Principles.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

Over the last two fiscal years, an average of 18.2 million people visited Florida's state parks. According to the Department of Environmental Protection (DEP), there are approximately158 state parks and 12 of these already have AEDs. These AEDS were either purchased by the department of received from donors.

Section 768.13, F.S., the Good Samaritan Act, provides immunity from civil liability to any persons, including those licensed to practice medicine, who gratuitously and in good faith render emergency care or treatment either in direct response to emergency situations related to and arising out of a state of emergency which has been declared pursuant to s. 252.36, F.S., or at the scent of an emergency outside of a hospital, doctor's office, or other place having proper medical equipment. Specifically as it relates to the use of an AED, s. 768.1325, F.S., the Cardiac Arrest Survival Act, provides immunity from liability for a person who uses or attempts to use an AED.

Background

The American Heart Association (AHA) describes a cardiac arrest as:

> Cardiac arrest is the sudden, abrupt loss of heart function. It is also called sudden cardiac arrest or unexpected cardiac arrest. Sudden death (also called sudden cardiac death) occurs within minutes after symptoms appear. The most common underlying reason for patients to die suddenly from cardiac arrest is coronary heart disease. Most cardiac arrests that lead to sudden death occur when the electrical impulses in the diseased heart become rapid (ventricular tachycardia) or chaotic (ventricular fibrillation) or both. This irregular heart rhythm (arrhythmia) causes the heart to suddenly stop beating.

According to the AHA, brain death and permanent death start to occur within 4 to 6 minutes after someone experiences cardiac arrest. Cardiac arrest can be reversed if it is treated within a few minutes with an electric shock to the heart to restore a normal heartbeat—a process called defibrillation. The AHA states that a victim's chances of survival are reduced by 7 to 10 percent with every passing minute without defibrillation, and few attempts at resuscitation succeed after 10 minutes.

An AED is an electronic device that can shock a person's heart back into rhythm when he or she is having a cardiac arrest. The AHA estimates that more than 95 percent of cardiac arrest victims die before reaching the hospital. In cases where defibrillation is provided within 5 to 7 minutes, the survival rate from sudden cardiac arrest can be up to 49 percent.

Section 401.2915, F.S., provides the minimum requirements for an individual who intends to use an AED in cases of cardiac arrest, as follows:

- A person must obtain appropriate training, to include completion of a course in cardiopulmonary resuscitation or successful completion of a basic first aid course that includes cardiopulmonary resuscitation training, and demonstrated proficiency in the use of an automated external defibrillator;

- A person or entity in possession of an automated external defibrillator is encouraged to register with the local emergency medical services medical director the existence and location of the automated external defibrillator; and
- A person who uses an automated external defibrillator is required to activate the emergency medical services system as soon as possible upon use of the automated external defibrillator.

Effect of Proposed Change

The bill would:

- Encourage each state park to have a functioning AED at all times.
- Require state parks that provide an AED to ensure that employees and volunteers are properly trained in accordance with s. 401.2915, F.S.
- Require the AED location to be registered with a local emergency medical services medical director.
- Provide that the Good Samaritan Act and the Cardiac Arrest Survival Act applies to AEDs used by employees and volunteers.

The bill provides that the Division of Recreation and Parks, Department of Environmental Protection, may adopt rules pursuant to s. 20.536(1), F.S., and s.120.54, F.S., to implement the provisions of this section of statue.

The bill appropriates $92,000 from the General Revenue Fund to the Division of Recreation and Parks, Department of Environmental Protection, for the purpose of implementing this act. According to the American Heart Association representatives, the average cost of an AED is approximately $1,500 to $1,800. Based on that average cost, this appropriation could fund an additional 118 to 142 AEDs for state parks.

C. SECTION DIRECTORY:

Section 1. Creates section. 258.0165, F.S., regarding defibrillators in state parks.

Section 2. Appropriates $92,000 from the General Revenue Fund to the Division of Recreation and Parks, Department of Environmental Protection, the purpose of implementing this act.

Section 3. Provides an effective day of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None

2. Expenditures:

   Non-Recurring Expense:

Department of Environmental Protection	Fiscal Year 2006-07
General Revenue Fund	$92,000
Total Expense	$92,000

Note: $92,000 in FY 2006-07 is appropriated to the Division of Recreation and Parks, Department of Environmental Protection for the purchase of as many AEDs as possible.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None

2. Expenditures:

None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

This bill would benefit the successful bidder on a contract to provide AEDs to state parks.

D. FISCAL COMMENTS:

None

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable because this bill does not appear to: require cities or counties to spend funds or take actions requiring the expenditure of funds; reduce the authority that cities or counties have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with cities or counties.

2. Other:

None

B. RULE-MAKING AUTHORITY:

This bill authorizes the Division of Recreation and Parks, Department of Environmental Protection to adopt rules to implement the provisions of s. 258.0165, F.S.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

A bill to be entitled

An act relating to defibrillators in state parks; creating s. 258.0165, F.S.; encouraging state parks to have a functioning automated external defibrillator; requiring training, maintenance, and location registration; providing immunity from liability under the Good Samaritan Act and the Cardiac Arrest Survival Act; authorizing the Division of Recreation and Parks to adopt rules; providing an appropriation; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 258.0165, Florida Statutes, is created to read:

258.0165 Defibrillators in state parks.--

(1) Each state park is encouraged to have on the premises at all times a functioning automated external defibrillator.

(2) State parks that provide automated external defibrillators shall ensure that employees and volunteers are properly trained in accordance with s. 401.2915.

(3) The location of each automated external defibrillator shall be registered with a local emergency medical services medical director.

(4) The use of automated external defibrillators by employees and volunteers shall be covered under the provisions of ss. 768.13 and 768.1325.

(5) The Division of Recreation and Parks may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this section.

Section 2. The sum of $92,000 is appropriated from the General Revenue Fund to the Division of Recreation and Parks of the Department of Environmental Protection for the purpose of implementing this act during the 2006-2007 fiscal year. The division shall arrange for the purchase of as many automated external defibrillators as may be purchased with this appropriation.

Section 3. This act shall take effect July 1, 2006.

President Bush's *National Strategy To Address A Pandemic*
Announced on November 1, 2005

1. **Preparedness and Communication:** Activities undertaken before a pandemic.

2. **Surveillance and Detection**: Systems to provide continuous awareness and early warnings.

3. **Response and Containment**: Actions to limit the spread of the outbreak and to mitigate the health, social and economic impacts of a pandemic.

Pillar One: Preparedness and Communication

Planning for a Pandemic / Communicating Expectations and Responsibilities
- Work with states, non-health entities and multilateral organizations to develop response plans.
- Expand in-country medical, veterinary and scientific capacity to respond to an outbreak.
- Work to ensure clear, effective and coordinated risk communication.
- Identify credible spokespersons at all levels of government to effectively coordinate and communicate helpful, informative messages in a timely manner.

Producing, Stockpiling & Distributing Vaccines, Antivirals and Medical Material
- Encourage and subsidize state-based stockpiles of vaccines, antivirals, meds and protective supplies.
- Ensure sufficient vaccine for front-line personnel and at-risk and military populations.
- Ensure sufficient vaccine and antiviral entire U.S. population within 6 months of outbreak.
- Facilitate appropriate coordination of efforts across the vaccine manufacturing sector.
- Address regulatory and other legal barriers to the expansion of our domestic vaccine production.
- Develop credible distribution mechanisms for vaccine and antivirals.

Advancing Scientific Knowledge and Accelerating Development
- Ensure that there is maximal sharing of scientific information about influenza viruses between entities.
- Accelerate the development of technology for vaccine and antiviral production.

Pillar Two: Surveillance and Detection

Ensuring Rapid Reporting of Outbreaks
- Work through international and national networks to guarantee rapid reporting of influenza cases.
- Advance mechanisms for "real-time" clinical surveillance in domestic acute care settings.
- Develop rapid diagnostics with greater sensitivity and reproducibility for onsite diagnosis.
- Expand our domestic livestock, wildlife, and tourism surveillance activities.

Pillar Three: Response and Containment

Containing Outbreaks / Leveraging National Medical and Public Health Surge Capacity
- The most effective way to protect the American population is to contain an outbreak beyond the borders of the U.S. However, slowing or limiting the spread of the outbreak is a more realistic.
- Where appropriate, offer and coordinate assistance from the US to affected regions of the world.
- Limit non-essential movement of people and goods from areas where an outbreak occurs.

Sustaining Infrastructure, Essential Services and the Economy / Effective Risk Communication
- Provide guidance to activate contingency plans to ensure that personnel are protected.
- Provide for the delivery of essential goods and services.
- Ensure that sectors remain functional despite significant and sustained worker absenteeism.
- Identify credible spokespersons at all levels of government.

Funding and the *Strategy*

The plan requests **$7.1 billion** to fund the three-part preparation strategy for a flu pandemic, whether it's caused by the bird flu or some other strain. The funding would go toward:

- Stockpiling vaccines and antiviral drugs
- Boosting vaccine production technology
- Putting in place an international bird flu surveillance program
- Assisting state and local preparedness plans.

$5 billion: To stockpile vaccines and antiviral medication and develop newer, faster manufacturing of vaccines.

$538 million: To help state and local governments create emergency plans

- The plan says states would pay about $510 million for enough anti-flu drugs such as Tamiflu and Relenza, which can reduce the severity of the illness, to treat 31 million people.

- The federal government would give states an incentive to make those purchases by providing a 25 percent match, or $170 million.

- Some say this is an unfunded mandate on the states and could mean that some states would not be able to buy enough drugs.

Highlights on the Role of States

The plan stresses three major steps that state and local authorities must begin taking now:

1. Update quarantine laws
2. Work with utilities to keep the phones working and grocers to keep supplying food amid panic
3. Determine when to close schools and limit public gatherings such as movies or religious services.

KEY FACTS

Information about Avian Influenza (Bird Flu) and Avian Influenza A (H5N1) Virus

This fact sheet provides general information about bird flu and information about one type of bird flu, called avian influenza A (H5N1) that is infecting birds in Asia and has infected some humans. Also see the Frequently Asked Questions (FAQs) on the World Health Organization (WHO) website.

What is avian influenza (bird flu)?

Bird flu is an infection caused by avian (bird) influenza (flu) viruses. These flu viruses occur naturally among birds. Wild birds worldwide carry the viruses in their intestines, but usually do not get sick from them. However, bird flu is very contagious among birds and can make some domesticated birds, including chickens, ducks, and turkeys, very sick and kill them.

Do bird flu viruses infect humans?

Bird flu viruses do not usually infect humans, but several cases of human infection with bird flu viruses have occurred since 1997.

How are bird flu viruses different from human flu viruses?

There are many different subtypes of type A flu viruses. These subtypes differ because of certain proteins on the surface of the flu A virus (hemagglutinin [HA] and neuraminidase [NA] proteins). There are 16 different HA subtypes and 9 different NA subtypes of flu A viruses. Many different combinations of HA and NA proteins are possible. Each combination is a different subtype. All subtypes of flu A viruses can be found in birds. However, when we talk about "bird flu" viruses, we are referring to those flu A subtypes that continue to occur mainly in birds. They do not usually infect humans, even though we know they can do so. When we talk about "human flu viruses" we are referring to those subtypes that occur widely in humans. There are only three known subtypes of human flu viruses (H1N1, H1N2, and H3N2); it is likely that some genetic parts of current human flu A viruses came from birds originally. Flu A viruses are constantly changing, and they might adapt over time to infect and spread among humans.

What are the symptoms of bird flu in humans?

Symptoms of bird flu in humans have ranged from typical flu-like symptoms (fever, cough, sore throat and muscle aches) to eye infections, pneumonia, severe respiratory diseases (such as acute respiratory distress), and other severe and life-threatening complications. The symptoms of bird flu may depend on which virus caused the infection.

How does bird flu spread?

Infected birds shed flu virus in their saliva, nasal secretions, and feces. Susceptible birds become infected when they have contact with contaminated excretions or surfaces that are contaminated with excretions. It is believed that most cases of bird flu infection in humans have resulted from contact with infected poultry or contaminated surfaces.

How is bird flu in humans treated?

Studies suggest that the prescription medicines approved for human flu viruses would work in preventing bird flu infection in humans. However, flu viruses can become resistant to these drugs, so these medications may not always work.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
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What is the risk to humans from bird flu?

The risk from bird flu is generally low to most people because the viruses occur mainly among birds and do not usually infect humans. However, during an outbreak of bird flu among poultry (domesticated chicken, ducks, turkeys), there is a possible risk to people who have contact with infected birds or surfaces that have been contaminated with excretions from infected birds. The current outbreak of avian influenza A (H5N1) among poultry in Asia (see below) is an example of a bird flu outbreak that has caused human infections and deaths. In such situations, people should avoid contact with infected birds or contaminated surfaces, and should be careful when handling and cooking poultry. For more information about avian influenza and food safety issues, visit the World Health Organization website at www.who.int/foodsafety/micro/avian/en.

What is an avian influenza A (H5N1) virus?

Influenza A (H5N1) virus – also called "H5N1 virus" – is an influenza A virus subtype that occurs mainly in birds. Like all bird flu viruses, H5N1 virus circulates among birds worldwide, is very contagious among birds, and can be deadly.

What is the H5N1 bird flu that has recently been reported in Asia?

Outbreaks of influenza H5N1 occurred among poultry in eight countries in Asia (Cambodia, China, Indonesia, Japan, Laos, South Korea, Thailand, and Vietnam) during late 2003 and early 2004. At that time, more than 100 million birds in the affected countries either died from the disease or were killed in order to try to control the outbreak. By March 2004, the outbreak was reported to be under control. Beginning in late June 2004, however, new deadly outbreaks of influenza H5N1 among poultry were reported by several countries in Asia (Cambodia, China, Indonesia, Malaysia [first-time reports], Thailand, and Vietnam). It is believed that these outbreaks are ongoing. Human infections of influenza A (H5N1) have been reported in Thailand, Vietnam and Cambodia.

What is the risk to humans from the H5N1 virus in Asia?

The H5N1 virus does not usually infect humans. In 1997, however, the first case of spread from a bird to a human was seen during an outbreak of bird flu in poultry in Hong Kong. The virus caused severe respiratory illness in 18 people, 6 of whom died. Since that time, there have been other cases of H5N1 infection among humans. Most recently, human cases of H5N1 infection have occurred in Thailand, Vietnam and Cambodia during large H5N1 outbreaks in poultry. The death rate for these reported cases has been about 50 percent. Most of these cases occurred from contact with infected poultry or contaminated surfaces; however, it is thought that a few cases of human-to-human spread of H5N1 have occurred.

So far, spread of H5N1 virus from person to person has been rare and spread has not continued beyond one person. However, because all influenza viruses have the ability to change, scientists are concerned that the H5N1 virus could one day be able to infect humans and spread easily from one person to another. Because these viruses do not commonly infect humans, there is little or no immune protection against them in the human population. If the H5N1 virus were able to infect people and spread easily from person to person, an "influenza pandemic" (worldwide outbreak of disease, see www.cdc.gov/flu/avian/gen-info/pandemics.htm) could begin. No one can predict when a pandemic might occur. However, experts from around the world are watching the H5N1 situation in Asia very closely and are preparing for the possibility that the virus may begin to spread more easily and widely from person to person.

How is infection with H5N1 virus in humans treated?

The H5N1 virus currently infecting birds in Asia that has caused human illness and death is resistant to amantadine and rimantadine, two antiviral medications commonly used for influenza. Two other antiviral

medications, oseltamavir and zanamavir, would probably work to treat flu caused by the H5N1 virus, though studies still need to be done to prove that they work.

Is there a vaccine to protect humans from H5N1 virus?

There currently is no vaccine to protect humans against the H5N1 virus that is being seen in Asia. However, vaccine development efforts are under way. Research studies to test a vaccine to protect humans against H5N1 virus began in April 2005. (Researchers are also working on a vaccine against H9N2, another bird flu virus subtype.) For more information about the H5N1 vaccine development process, visit the National Institutes of Health website at http://www2.niaid.nih.gov/Newsroom/Releases/flucontracts.htm.

What is the risk to people in the United States from the H5N1 bird flu outbreak in Asia?

The current risk to Americans from the H5N1 bird flu outbreak in Asia is low. The strain of H5N1 virus found in Asia has not been found in the United States. There have been no human cases of H5N1 flu in the United States. It is possible that travelers returning from affected countries in Asia could be infected. Since February 2004, medical and public health personnel have been watching closely to find any such cases.

What does CDC recommend regarding the H5N1 bird flu outbreak in Asia?

In February 2004, CDC provided U.S. health departments with recommendations for enhanced surveillance ("detection") in the U.S. of avian influenza A (H5N1). Follow-up messages (Health Alert Network) were sent to the health departments on August 12, 2004, and February 4, 2005, both reminding health departments about how to detect (domestic surveillance), diagnose, and prevent the spread of avian influenza A (H5N1). It also recommended measures for laboratory testing for H5N1 virus. CDC currently advises that travelers to countries in Asia with known outbreaks of influenza A (H5N1) avoid poultry farms, contact with animals in live food markets, and any surfaces that appear to be contaminated with feces from poultry or other animals.

What is CDC doing to prepare for a possible H5N1 flu pandemic?

CDC is taking part in a number of pandemic prevention and preparedness activities, including:

- Working with the Association of Public Health Laboratories on training workshops for state laboratories on the use of special laboratory (molecular) techniques to identify H5 viruses.
- Working with the Council of State and Territorial Epidemiologists and others to help states with their pandemic planning efforts.
- Working with other agencies such as the Department of Defense and the Veterans Administration on antiviral stockpile issues.
- Working with the World Health Organization (WHO) and Vietnamese Ministry of Health to investigate influenza H5N1 in Vietnam and to provide help in laboratory diagnostics and training to local authorities.
- Performing laboratory testing of H5N1 viruses.
- Starting a $5.5 million initiative to improve influenza surveillance in Asia.
- Holding or taking part in training sessions to improve local capacities to conduct surveillance for possible human cases of H5N1 and to detect influenza A H5 viruses by using laboratory techniques.
- Developing and distributing reagents kits to detect the currently circulating influenza A H5N1 viruses.
- Working together with WHO and the National Institutes of Health (NIH) on safety testing of vaccine seed candidates and to develop additional vaccine virus seed candidates for influenza A (H5N1) and other subtypes of influenza A virus.

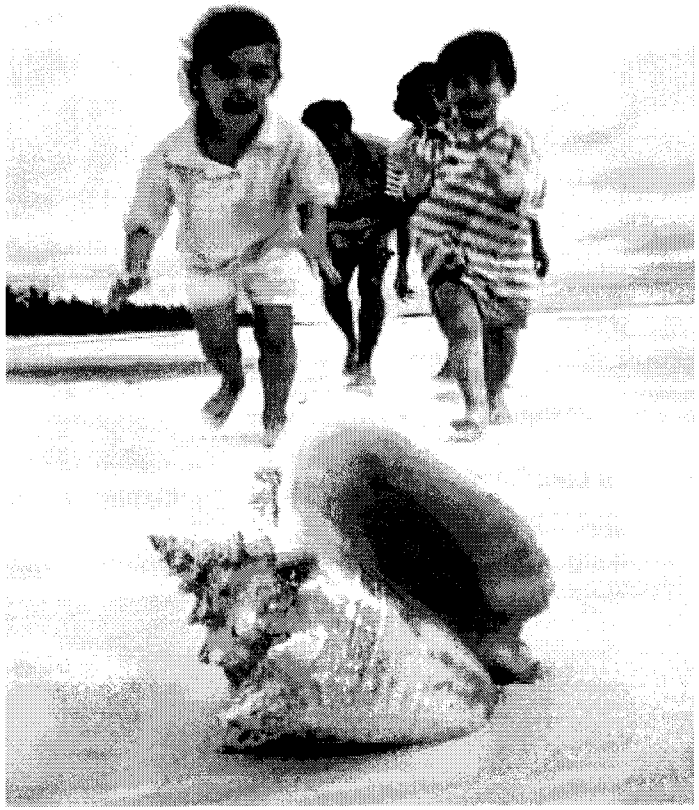
For more information, visit www.cdc.gov/flu,
or call CDC at 800-CDC-INFO (English and Spanish) or 888-232-6348 (TTY).

Presentation
on
Payer-Based Health Records

Jon McBride, Chief Technology Officer
Availity

Payer-Based Health Records

delivered via the existing Availity® health information network to improve health care delivery and enhance patient experience



BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

HUMANA
Guidance when you need it most

Introduction

- Health care industry is pursuing solutions that facilitate the sharing and interoperability of health information
- Significant opportunity for collaboration among healthcare stakeholders to develop an effective health information system
- Blue Cross and Blue Shield of Florida (BCBSF) and Humana recognize the importance and value of technology in improving health care delivery
- BCBSF and Humana have developed a prototype of a **payer-based health record** and is actively developing a multi-payer based capability leveraging Availity's proven statewide infrastructure

Overview of Payer-Based Health Records

- A payer-based health record is a record compiled from claims data submitted by providers to health plans
  - Health plans are currently the only stakeholder in the health care system that collects information from almost all providers that their members visit

- This means that it is the only cross-provider view of patient history available to physicians
  - Member claims history available from all hospitals, physicians, labs, and pharmacies
  - Includes other facilities that file insurance claims
  - All Florida physicians and hospitals can access the payer-based health record

- Quick, easy access to patient's encounters across health care system
  - Prescription drug history
  - Lab history
  - Radiology history
  - History of visits to doctors and hospitals
  - Immunization history
  - Diagnosis detail

Future Enhancements:
- Lab and radiology results
- Drug to drug interactions
- Care gap alerts

Overview of Payer-Based Health Records (con't)

- Proven security
  - HIPAA compliant
  - Only accessible by authorized personnel
  - Complete audit trail

- Available to all third party payers who wish to participate
  - BlueCross and BlueShield of Florida and Humana are working jointly to introduce the capability
  - All other Florida health plans and third party payers will be invited to participate in future releases
  - As Availity moves to other states, the capability will be available to those health plans participating with Availity's provider portal
    - The Arizona all-payer portal will launch later this year

No New Data or Infrastructure Required

- Uses claims data that are already submitted by providers and stored in health plan databases

- Requires no new infrastructure
  - Uses the Availity system that BlueCross and BlueShield of Florida and Humana pioneered to simplify claims submission and eligibility and benefits inquiries
  - Availity is currently installed in all Florida Hospitals and 93% of Florida's doctor offices

- Doctors offices only need high speed internet access and a web browser (which most already have)
  - Web access allows doctors to securely access patient information from any internet browser
  - Doctors can log on from home or other remote locations (even outside Florida)
  - Should their offices be closed, during natural disasters for example, access would still be available through the Internet regardless of location

- Easily integrated into physicians clinical workflow
  - All records can be printed and placed in clinical folder
  - Customizable to adapt to physician's preferred view of patient history

Architecturally Sound Solution

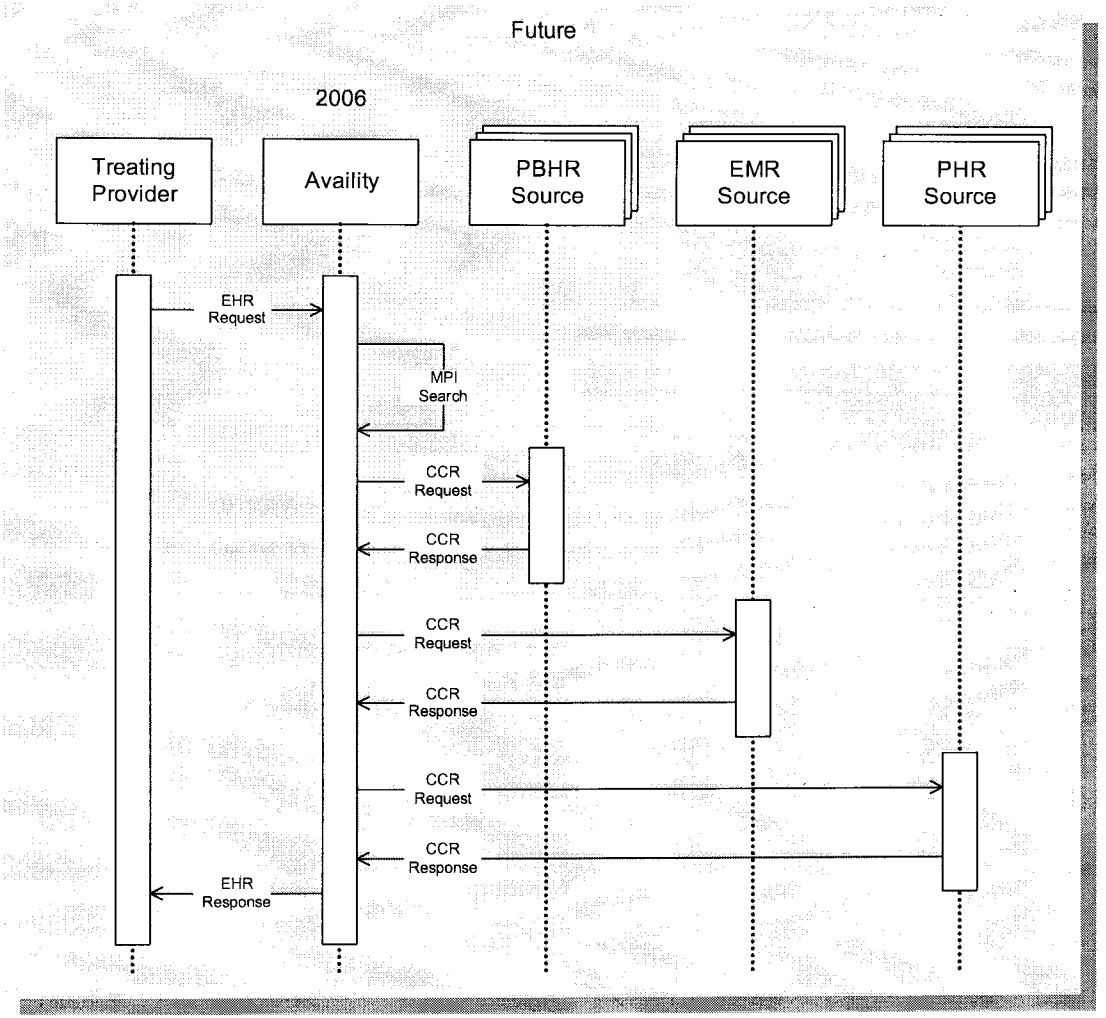
- "Federated" model does not require centralized databases
  - Health information remains stored in health plan databases
  - Allows a consolidated record to be compiled from all health plans who participate to create a longitudinal view of patients' histories
  - Other sources of data can be added (e.g., State of Florida's SHOTs immunization database)

- State-of-the-art disaster recovery
  - BlueCross and BlueShield of Florida, Humana, and Availity have procedures and processes that will allow physicians almost immediate access to patient information should the need arise
  - Disaster recovery systems reside outside of Florida to guard against Florida-specific disasters (e.g., hurricanes)

Future State of Electronic Health Records

Invite participation by all stakeholders who support continuity of care record (CCR) transactions and standards to create the full longitudinal, interoperable electronic health record

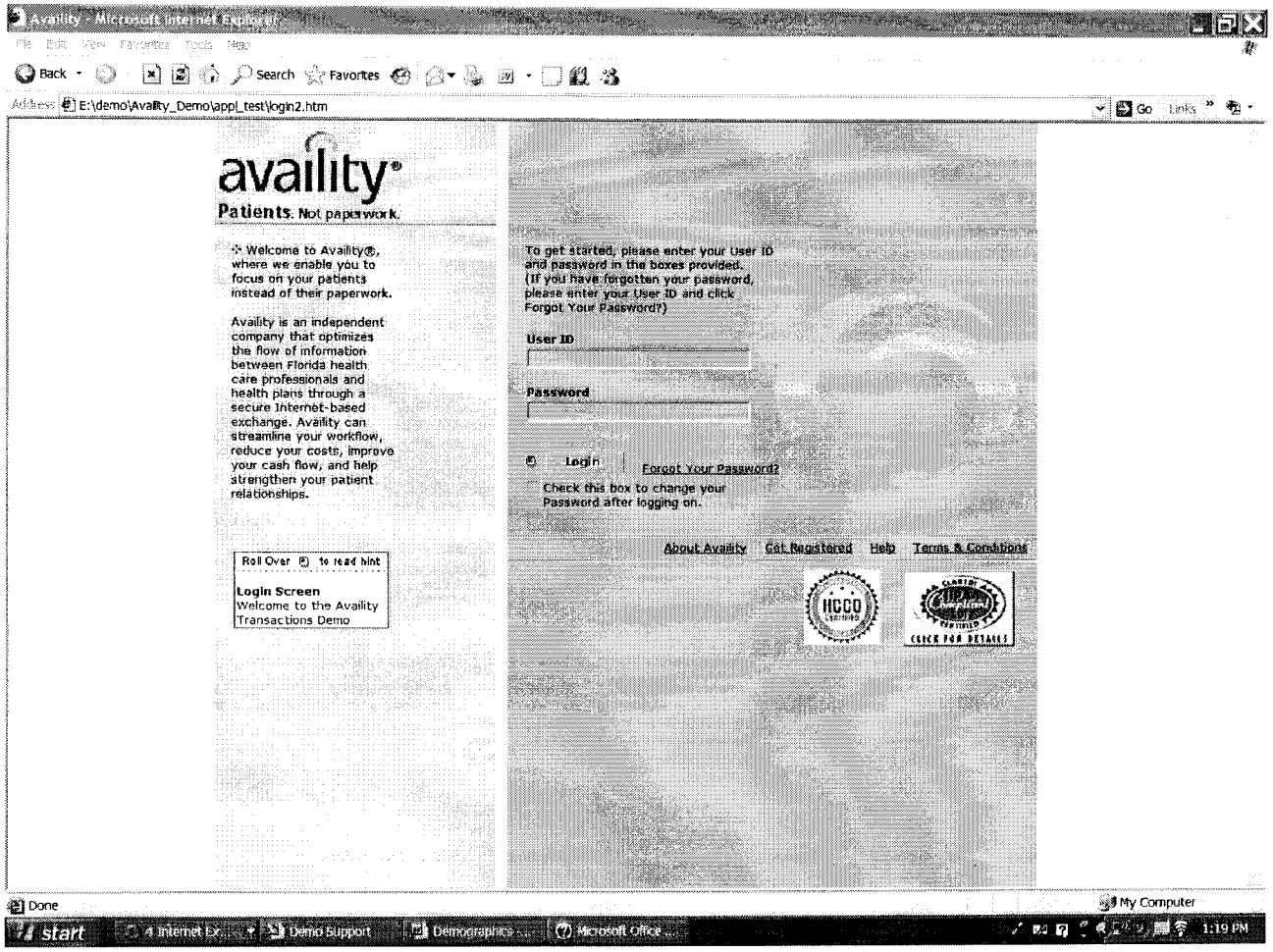
- EMR (PMS, HIS) vendors
- PHR vendors
- RHIOs
- Other sources of information (lab orders, PBMs, etc)



MPI: Master Patient/Person Index
PMS: Practice Management System
EMR: Electronic Medical Record
HIS: Health Information System
PHR: Personal Health Record

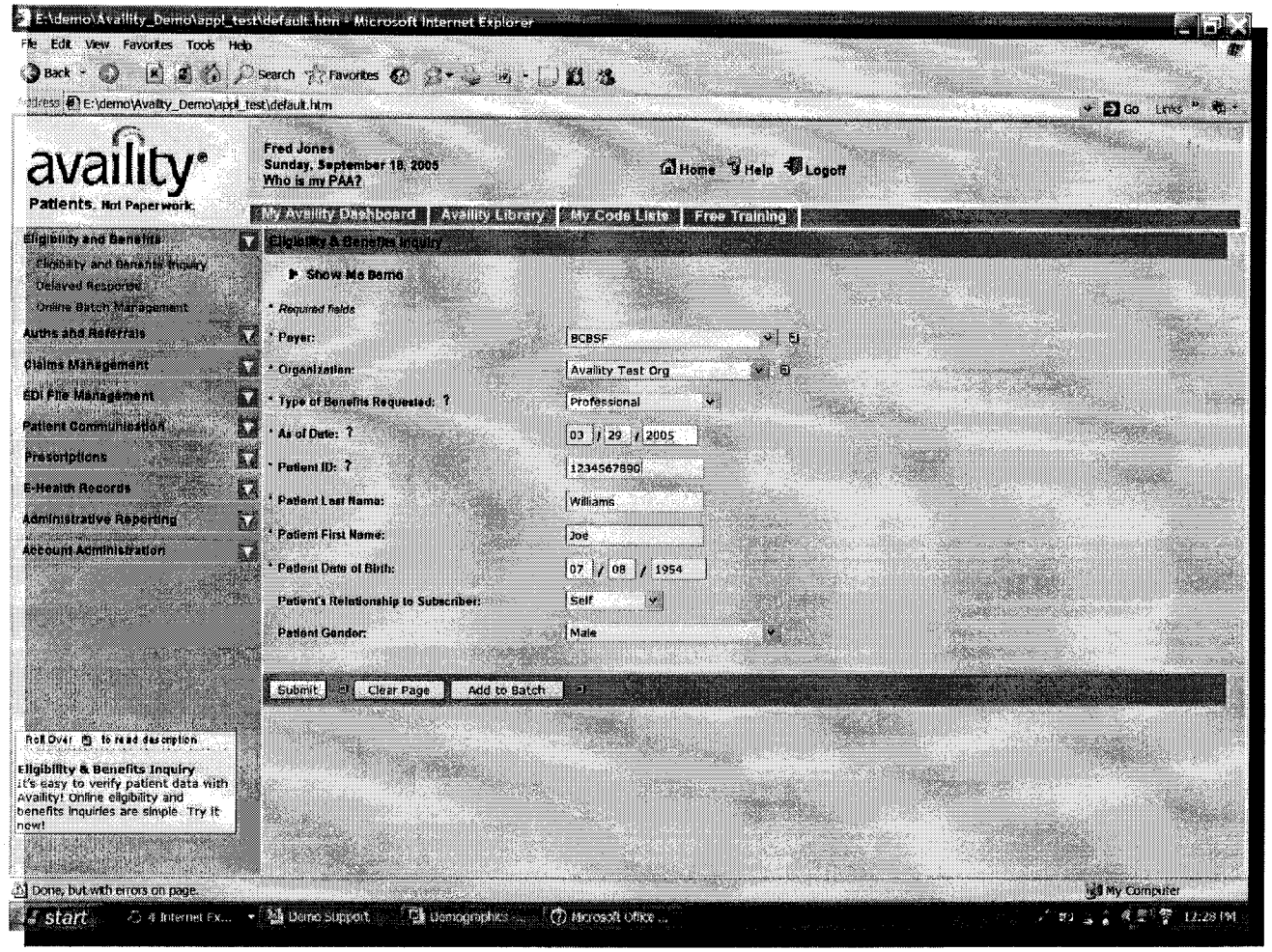
Same Log-On Currently Used in Most Doctors' Offices

- Proven security
- Intuitive user interface
- No new processes or software for current Availity users



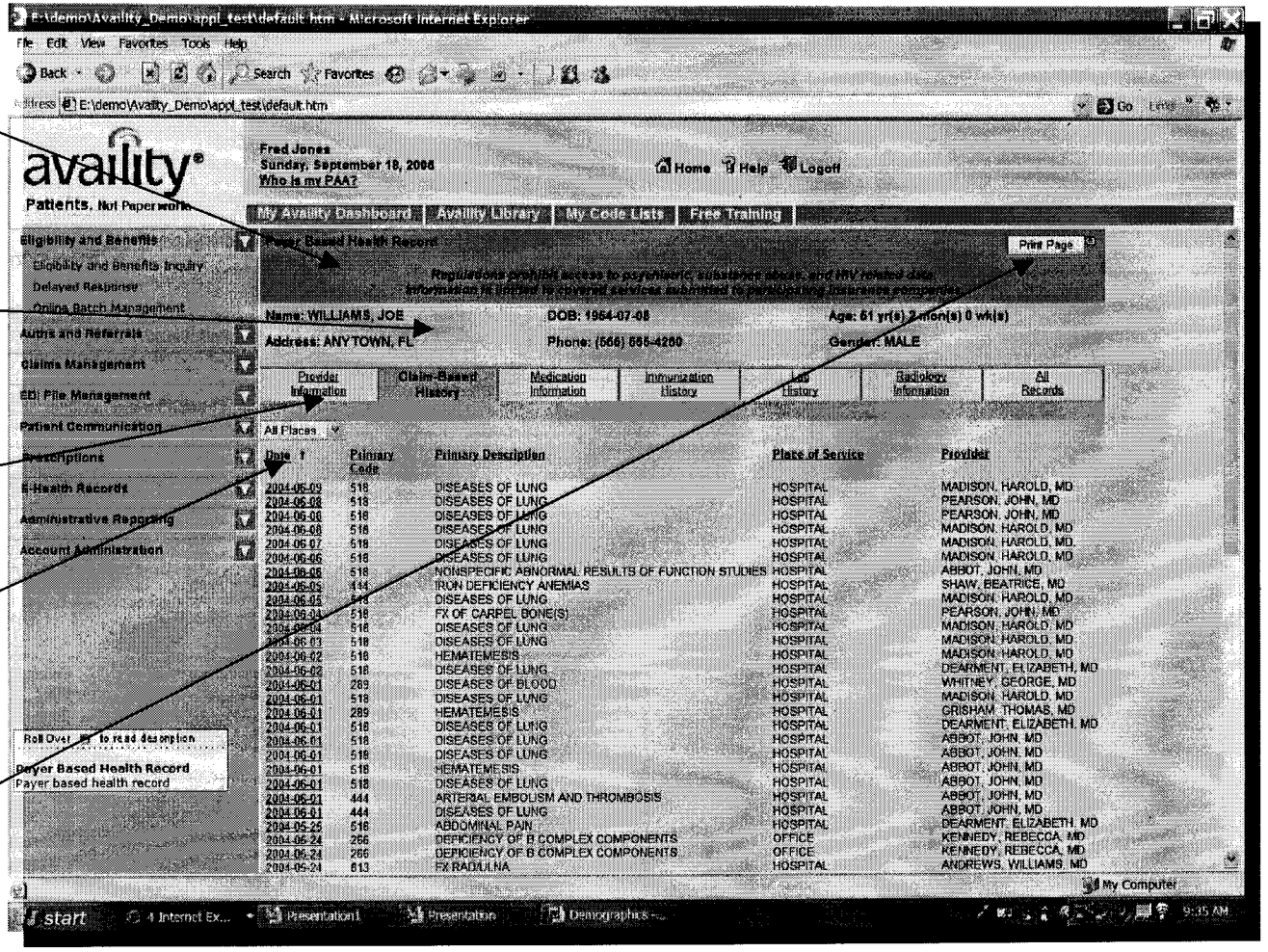
Secure Access

- Patient's name, health plan ID number, and date of birth required for access
- Prevents random browsing of payer-based health record



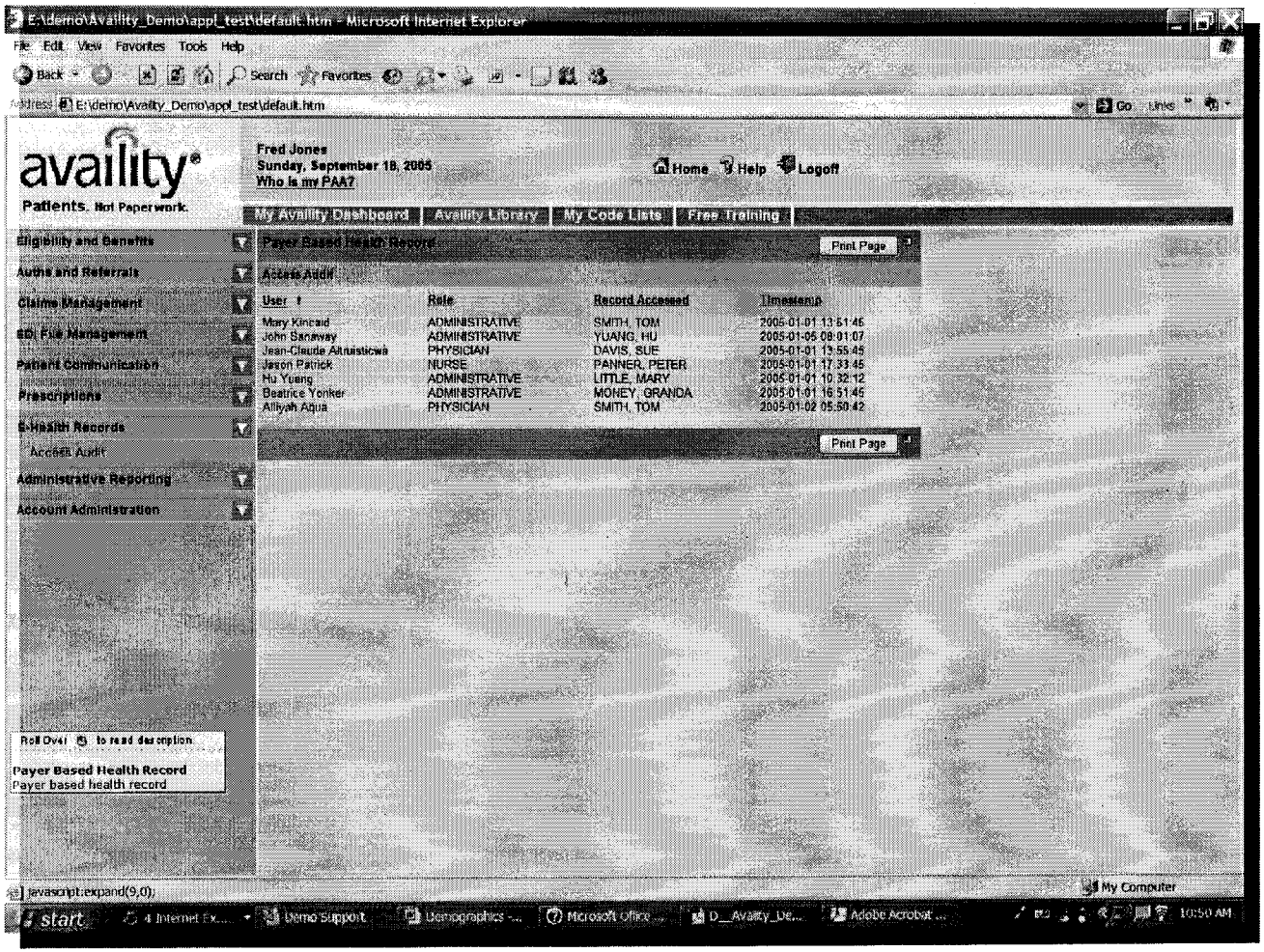
Organization and Navigation

- Disclaimers to remind physicians of legal, regulatory, and other limitations
- Demographic information displayed on all screens
- Simple navigation to all information
- All fields can be sort in ascending or descending order by clicking on the field name
- All information can be easily printed

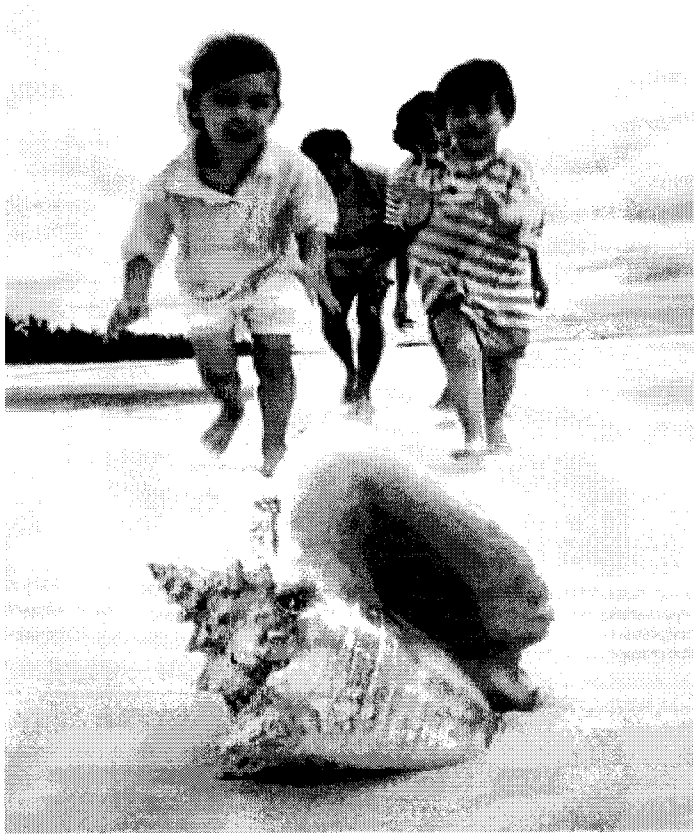


Providers Know who Accesses Records

- Access is recorded
- Doctors can see who in their offices access the system
- They know which patients' records were accessed
- They know when they were accessed



Case Studies



BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

HUMANA

Guidance when you need it most

Joe Williams

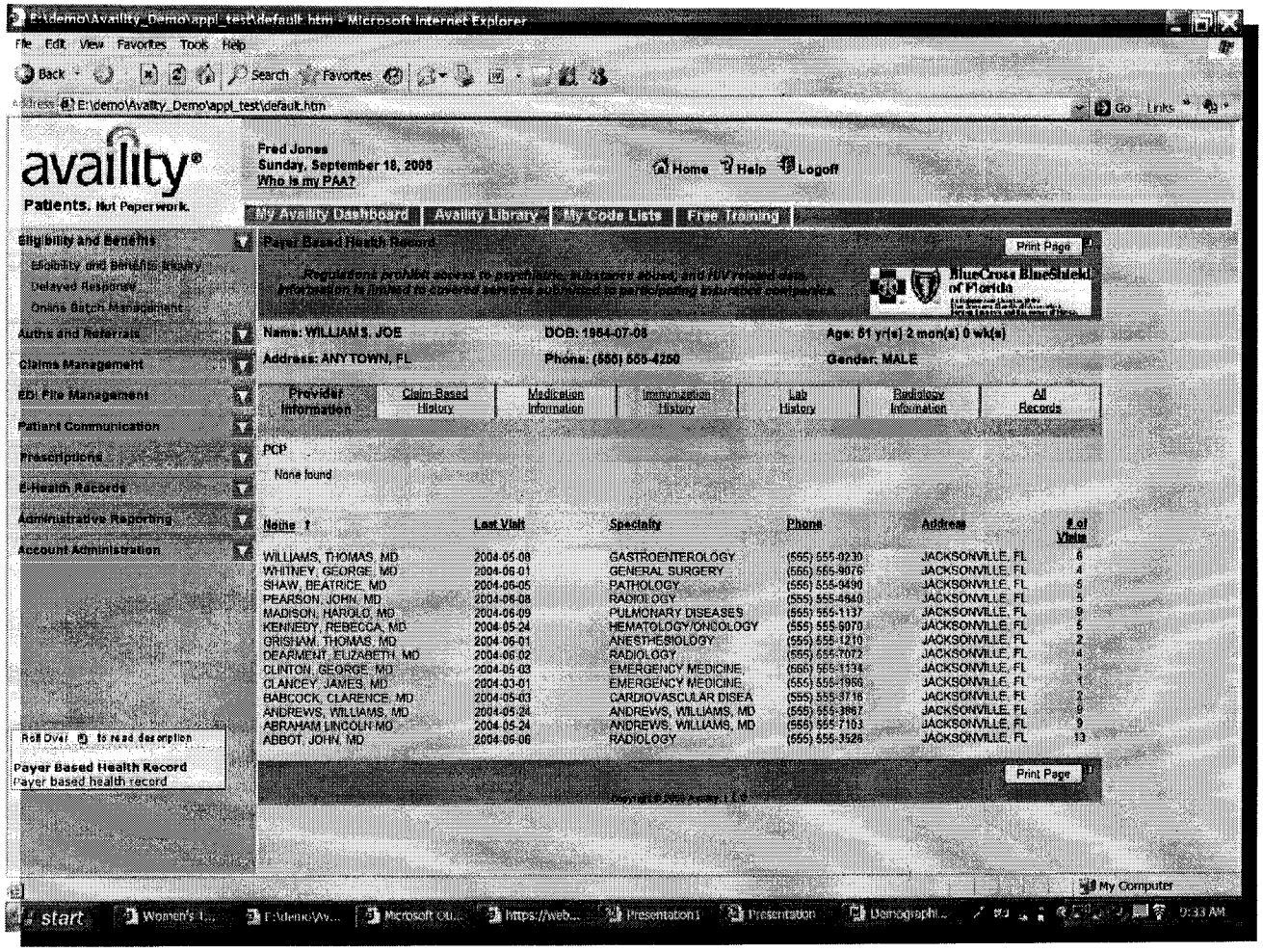
This is a multiple Medical Problem Case

- This member is likely to show up in the ER or Urgent Care facility with complaint of abdominal pain
- This patient has not been seen before by the attending physician
- Patient does not share his complete history nor knows what medication that they are currently taking
- The doctor is able to access the Payer-based Health Record
- The breadth of the specialties that Joe Williams has visited raises the physicians' attention.
- The claims based history provides a indication of past diagnosis:
  - Lung problems
  - Vomiting up blood
  - Wrist injury
- The medication page provides that actual name of the prescriptions that he has been prescribed

The value of the PBHR in this case is that it identifies the medicine and provides the history of pulmonary problems – fills the gap for the physician

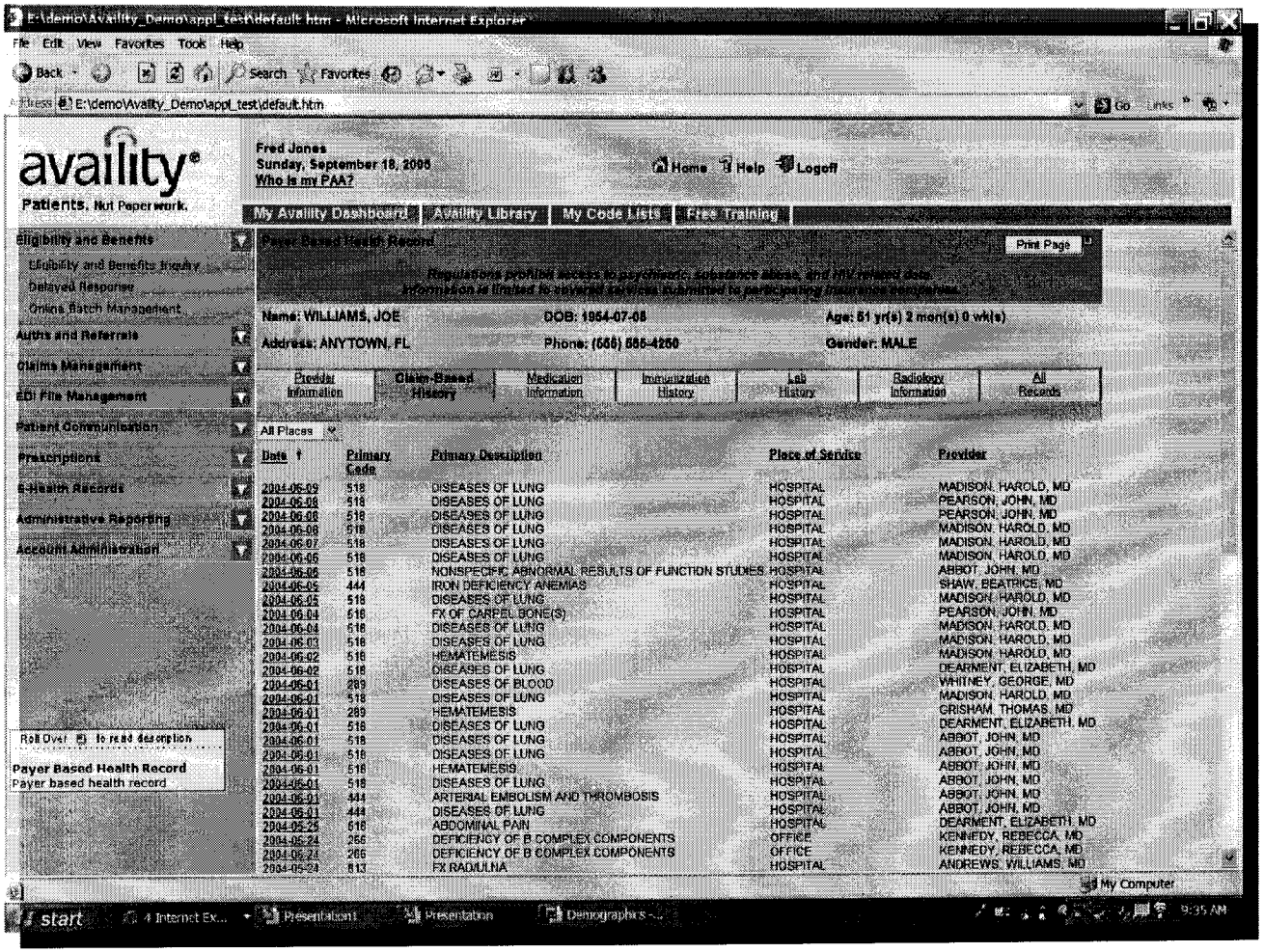
Overview of Physicians and Facilities Visited

- Doctors visited
- When they were visited
- Doctor's specialty
- Number of visits to each physician
- How to contact the physician



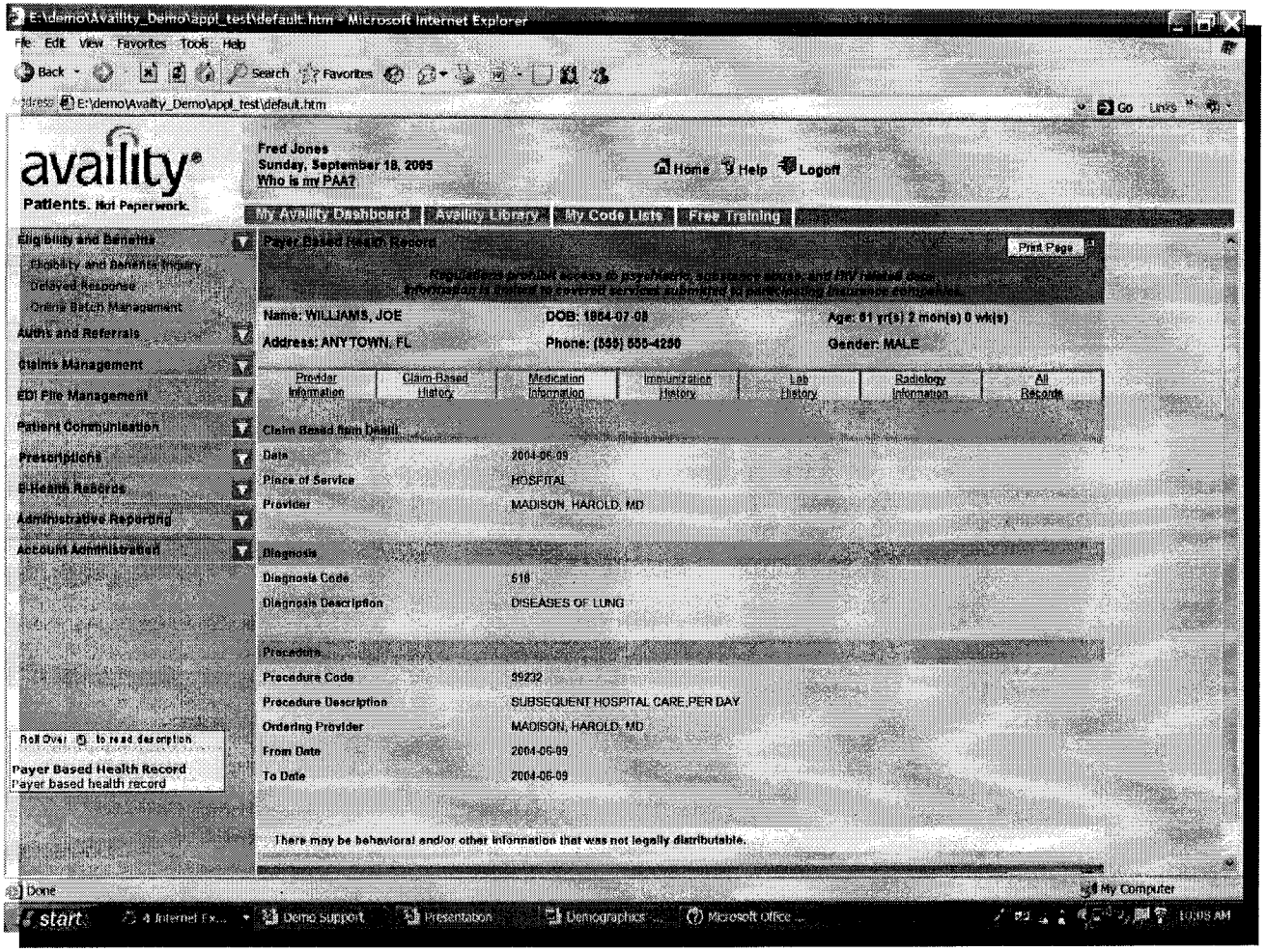
Patient's Diagnostic History

- Diagnostic history
- Where the service was rendered
- Date of service
- Doctor's name
- Hyperlink to detail



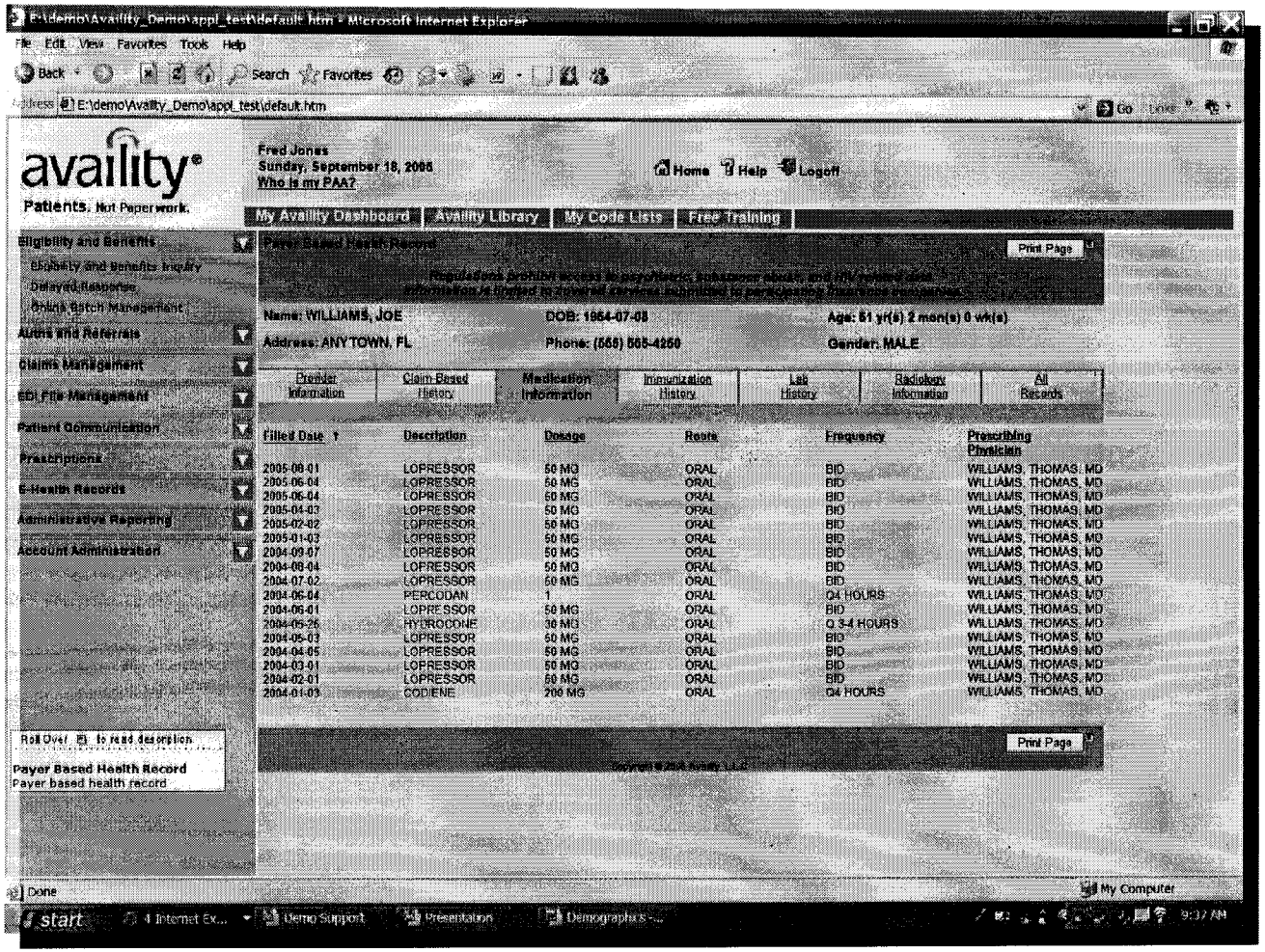
Diagnostic Detail Associated with Patient's Visits

- Detail on where service was rendered
- Details on procedures associated with diagnosis



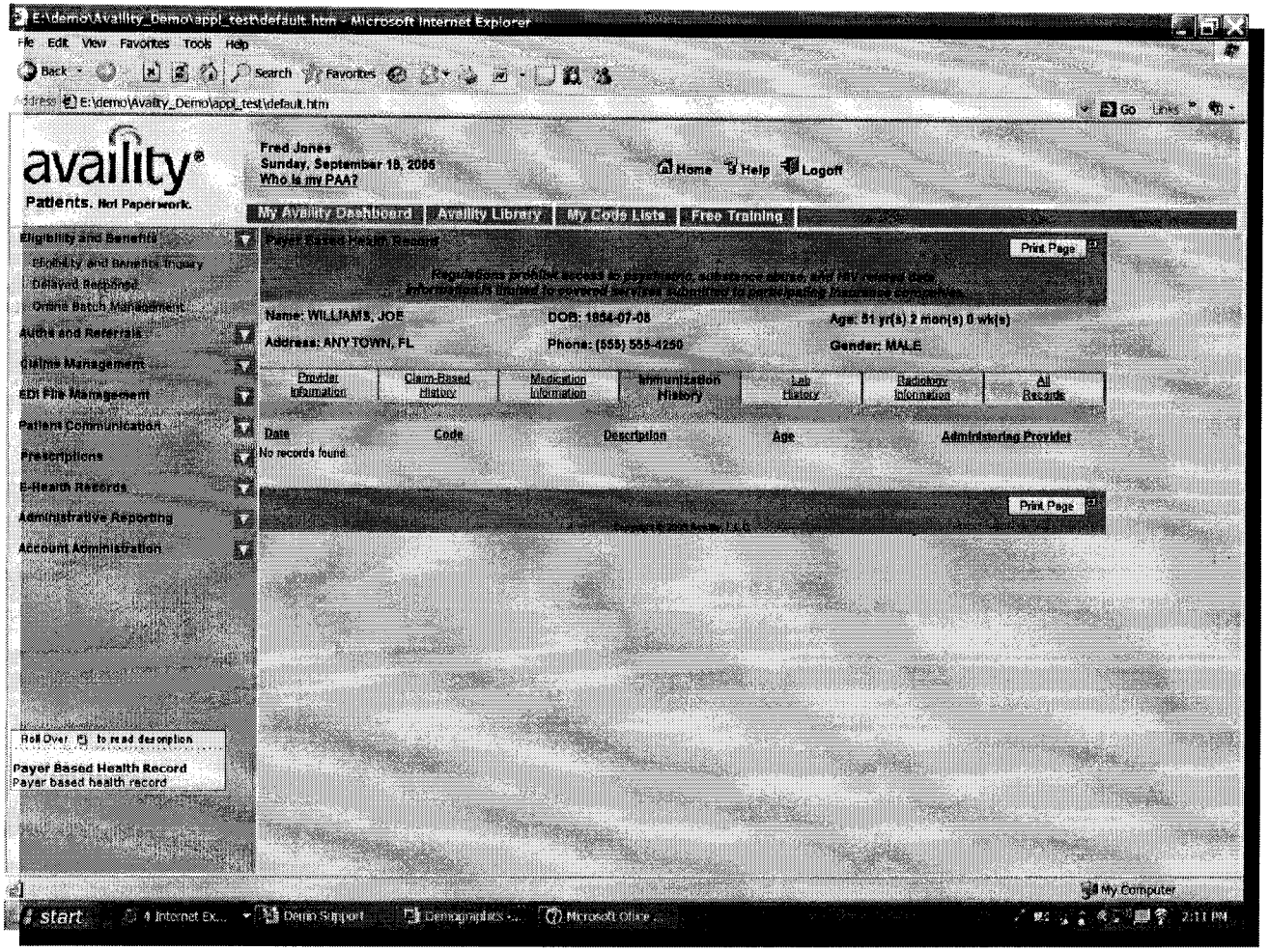
Patient's Prescription Drug History

- History of drugs filled
- When drug was filled
- Prescribing physician
- Prescribed dosage and frequency



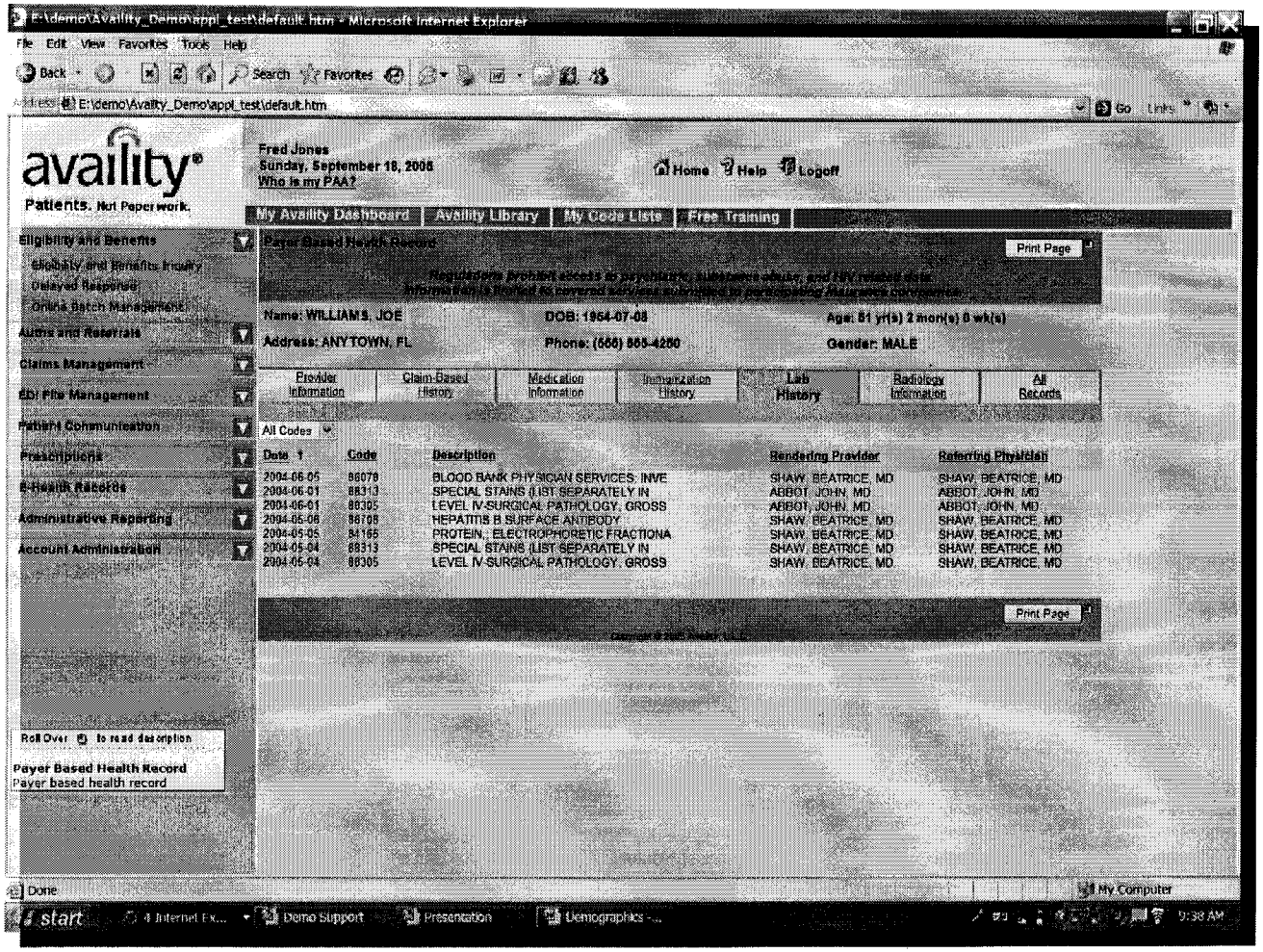
Patient's Immunization History

- Doctors have access to immunization history
- Doctors are informed when no records are found



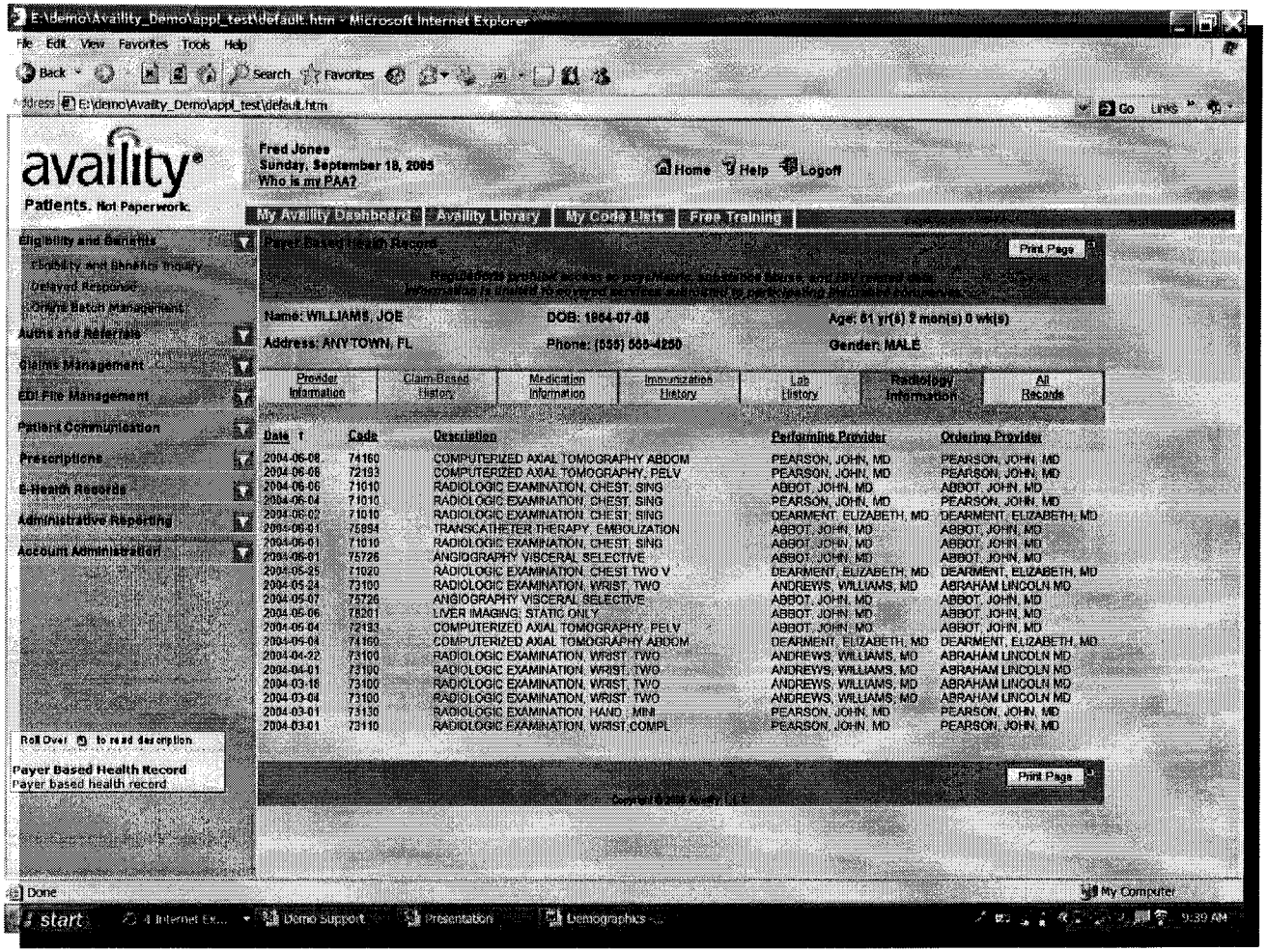
Patient's Lab History

- History of lab tests
- Name of labs that rendered services
- Name of physician who ordered tests
- Date of service



Patient's Radiology History

- History of x-rays, MRIs, CAT scans, and other imaging techniques
- Where the service was rendered
- Date of service
- Name of ordering physician



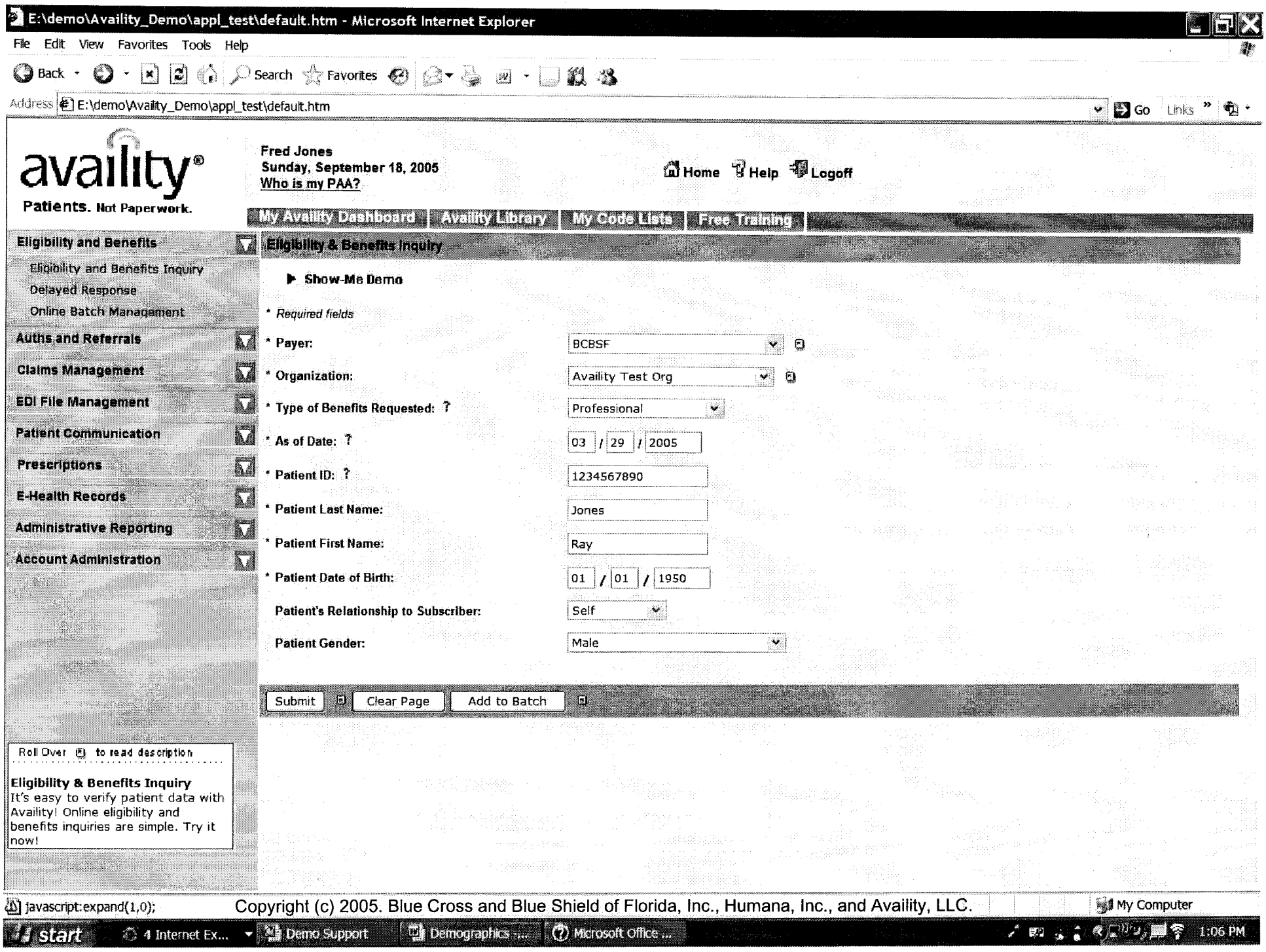
Ray Jones

This is a Chronic Care Case with care gaps:

- This member is seeing physicians frequently for his Diabetes condition
- The only other physician is an ophthalmologist for retinal exams
- The patient's blood sugar is being regularly checked
- The patient now needs HBA1C to be in compliance with current disease management practices.
- The physician has been educated about disease management specifics through the BCBSF RPE program
- The patient has been educated about the appropriate care through the chronic care management program

The value of the PBHR in this case is that it bridges the gap of what BCBSF is doing today

- *by putting data in front of the physician when the patient is in front of them*
- *measuring patient compliance with physician orders*
- *and provides the ability to understand the outcomes of implementing of the treatment plan*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Show-Me Demo
* Required fields
* Payer: BCBSF
* Organization: Availity Test Org
* Type of Benefits Requested: Professional
* As of Date: 03 / 29 / 2005
* Patient ID: 1234567890
* Patient Last Name: Jones
* Patient First Name: Ray
* Patient Date of Birth: 01 / 01 / 1950
Patient's Relationship to Subscriber: Self
Patient Gender: Male
Submit
Clear Page
Add to Batch
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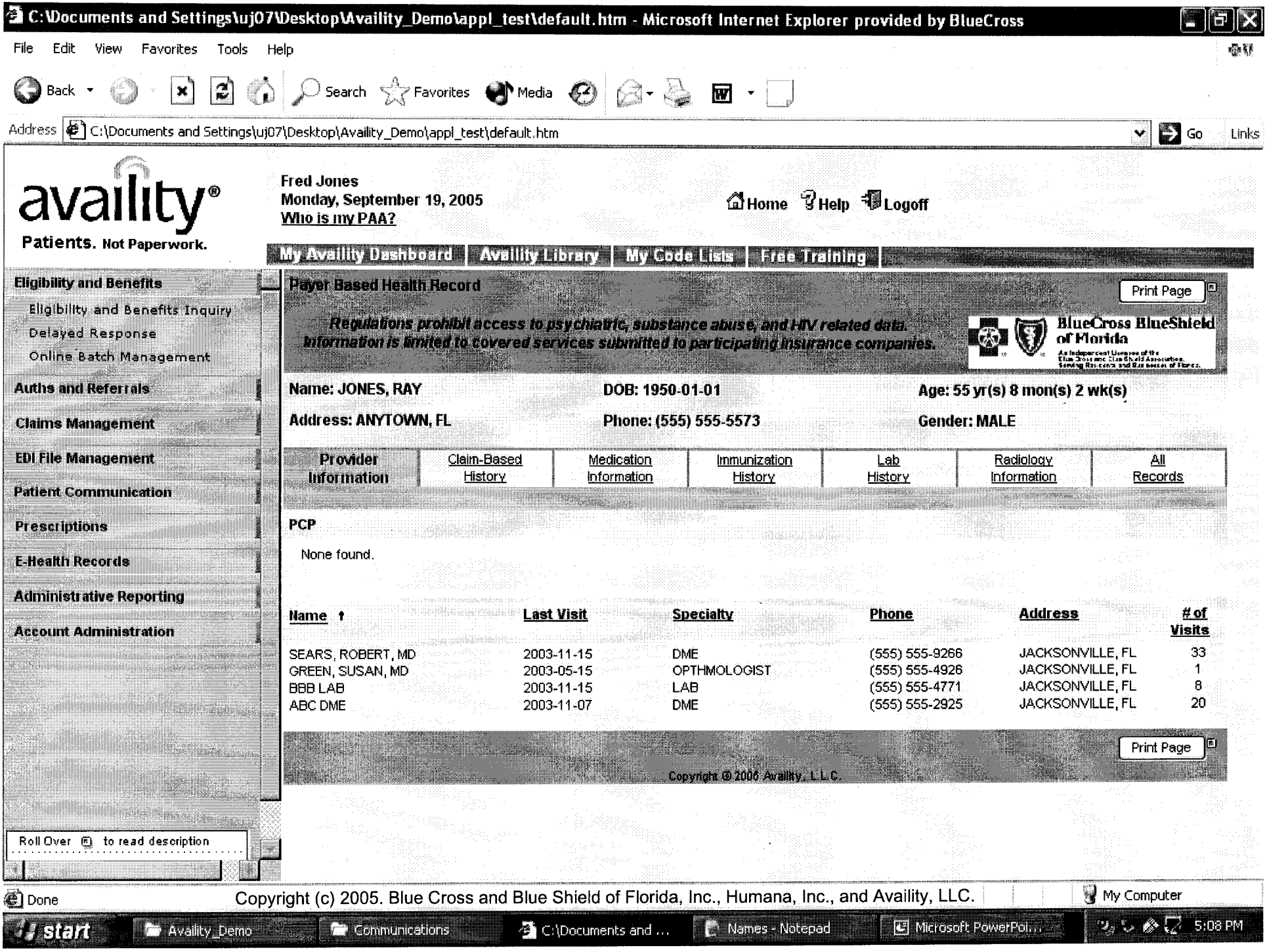
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Payer Based Health Record
Print Page
Regulations prohibit access to psychiatric, substance abuse, and HIV related data.
Information is limited to covered services submitted to participating insurance companies.
BlueCross BlueShield of Florida
Name: JONES, RAY
DOB: 1950-01-01
Age: 55 yr(s) 8 mon(s) 2 wk(s)
Address: ANYTOWN, FL
Phone: (555) 555-5573
Gender: MALE
Provider Information
Claim-Based History
Medication Information
Immunization History
Lab History
Radiology Information
All Records
PCP
None found.
Name
Last Visit
Specialty
Phone
Address
# of Visits
SEARS, ROBERT, MD 2003-11-15 DME (555) 555-9266 JACKSONVILLE, FL 33
GREEN, SUSAN, MD 2003-05-15 OPTHMOLOGIST (555) 555-4926 JACKSONVILLE, FL 1
BBB LAB 2003-11-15 LAB (555) 555-4771 JACKSONVILLE, FL 8
ABC DME 2003-11-07 DME (555) 555-2925 JACKSONVILLE, FL 20
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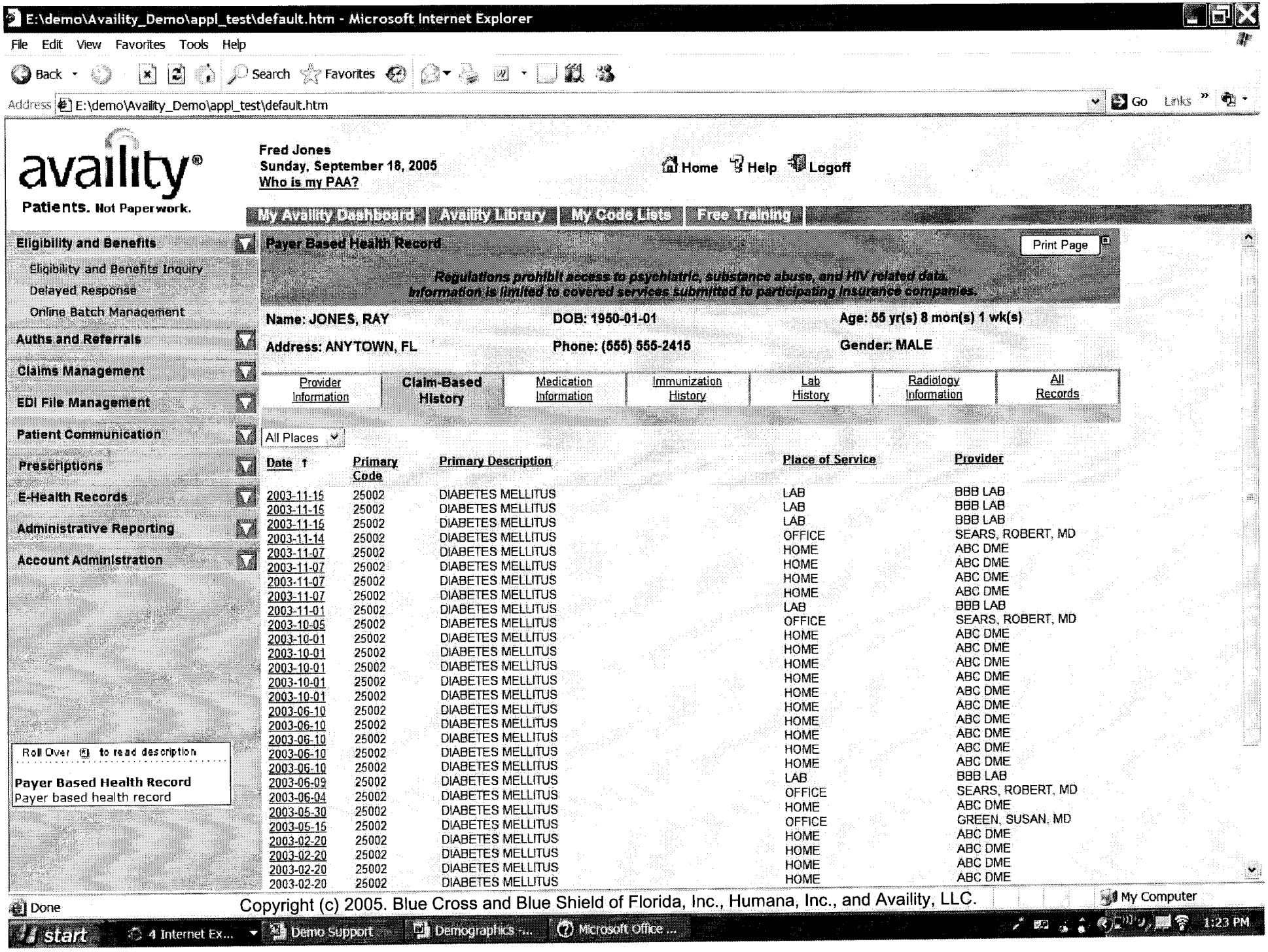
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Payer based health record
Payer Based Health Record
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Name: JONES, RAY
DOB: 1950-01-01
Age: 55 yr(s) 8 mon(s) 1 wk(s)
Address: ANYTOWN, FL
Phone: (555) 555-2415
Gender: MALE
Provider Information
Claim-Based History
Medication Information
Immunization History
Lab History
Radiology Information
All Records
All Places
Date
Primary Code
Primary Description
Place of Service
Provider
2003-11-15 25002 DIABETES MELLITUS LAB BBB LAB
2003-11-15 25002 DIABETES MELLITUS LAB BBB LAB
2003-11-15 25002 DIABETES MELLITUS LAB BBB LAB
2003-11-14 25002 DIABETES MELLITUS OFFICE SEARS, ROBERT, MD
2003-11-07 25002 DIABETES MELLITUS HOME ABC DME
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2003-02-20 25002 DIABETES MELLITUS HOME ABC DME
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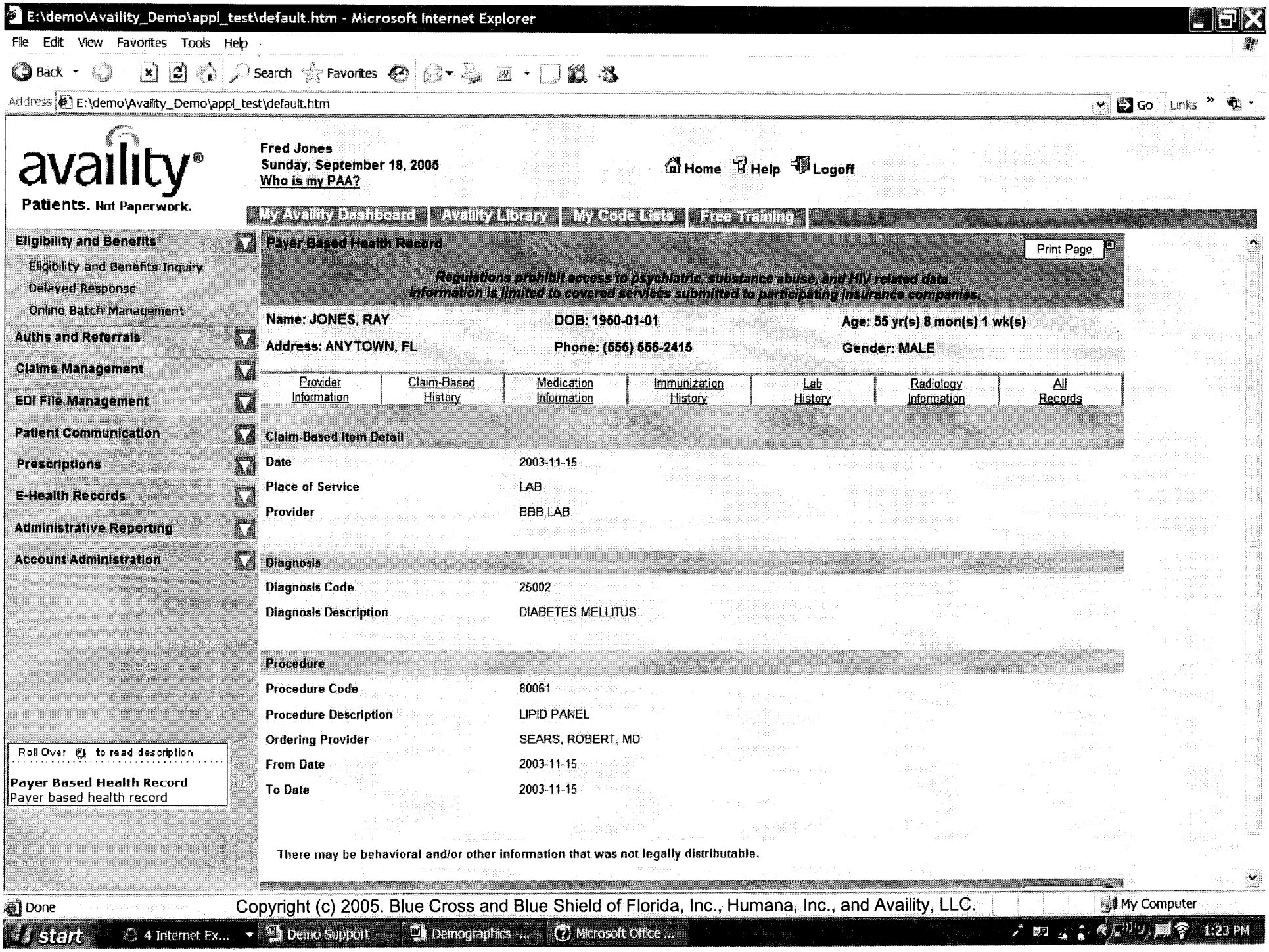
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Name: JONES, RAY
DOB: 1950-01-01
Age: 55 yr(s) 8 mon(s) 1 wk(s)
Address: ANYTOWN, FL
Phone: (555) 555-2415
Gender: MALE
Provider Information
Claim-Based History
Medication Information
Immunization History
Lab History
Radiology Information
All Records
Claim-Based Item Detail
Date 2003-11-15
Place of Service LAB
Provider BBB LAB
Diagnosis
Diagnosis Code 25002
Diagnosis Description DIABETES MELLITUS
Procedure
Procedure Code 80061
Procedure Description LIPID PANEL
Ordering Provider SEARS, ROBERT, MD
From Date 2003-11-15
To Date 2003-11-15
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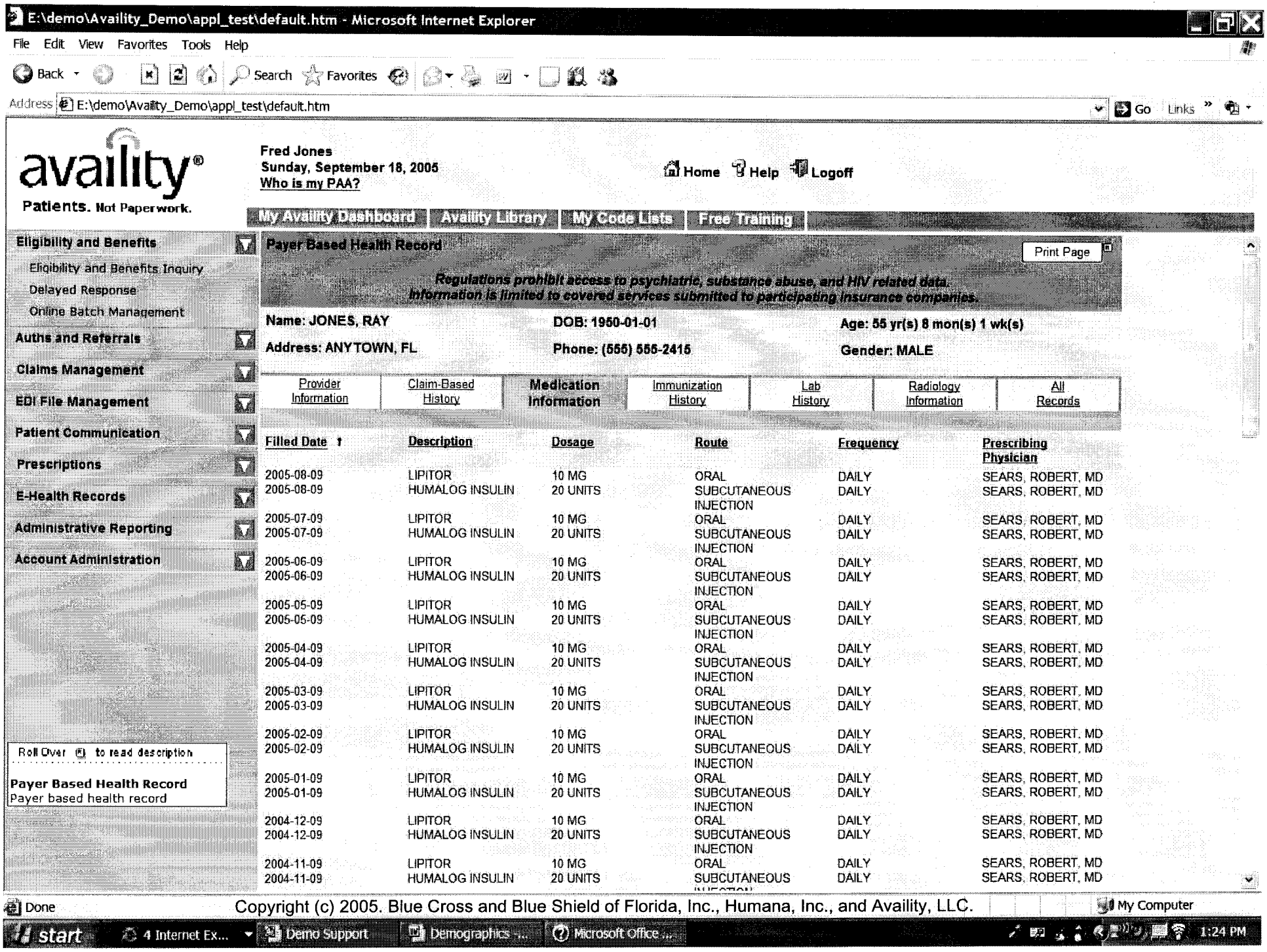
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DOB: 1950-01-01
Age: 55 yr(s) 8 mon(s) 1 wk(s)
Address: ANYTOWN, FL
Phone: (555) 555-2415
Gender: MALE
Provider Information
Claim-Based History
Medication Information
Immunization History
Lab History
Radiology Information
All Records
Filled Date
Description
Dosage
Route
Frequency
Prescribing Physician
2005-08-09 LIPITOR 10 MG ORAL DAILY SEARS, ROBERT, MD
2005-08-09 HUMALOG INSULIN 20 UNITS SUBCUTANEOUS INJECTION DAILY SEARS, ROBERT, MD
2005-07-09 LIPITOR 10 MG ORAL DAILY SEARS, ROBERT, MD
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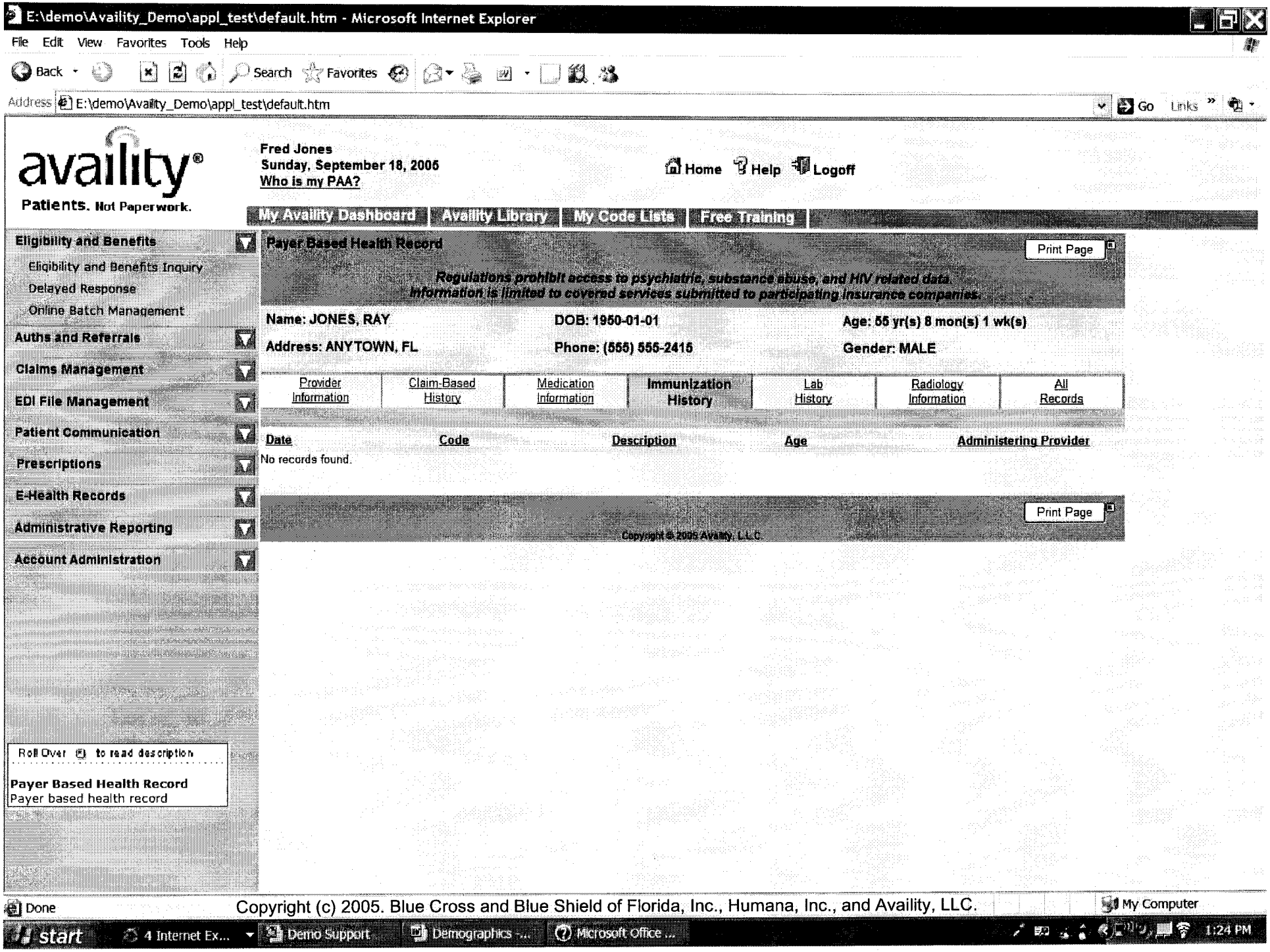

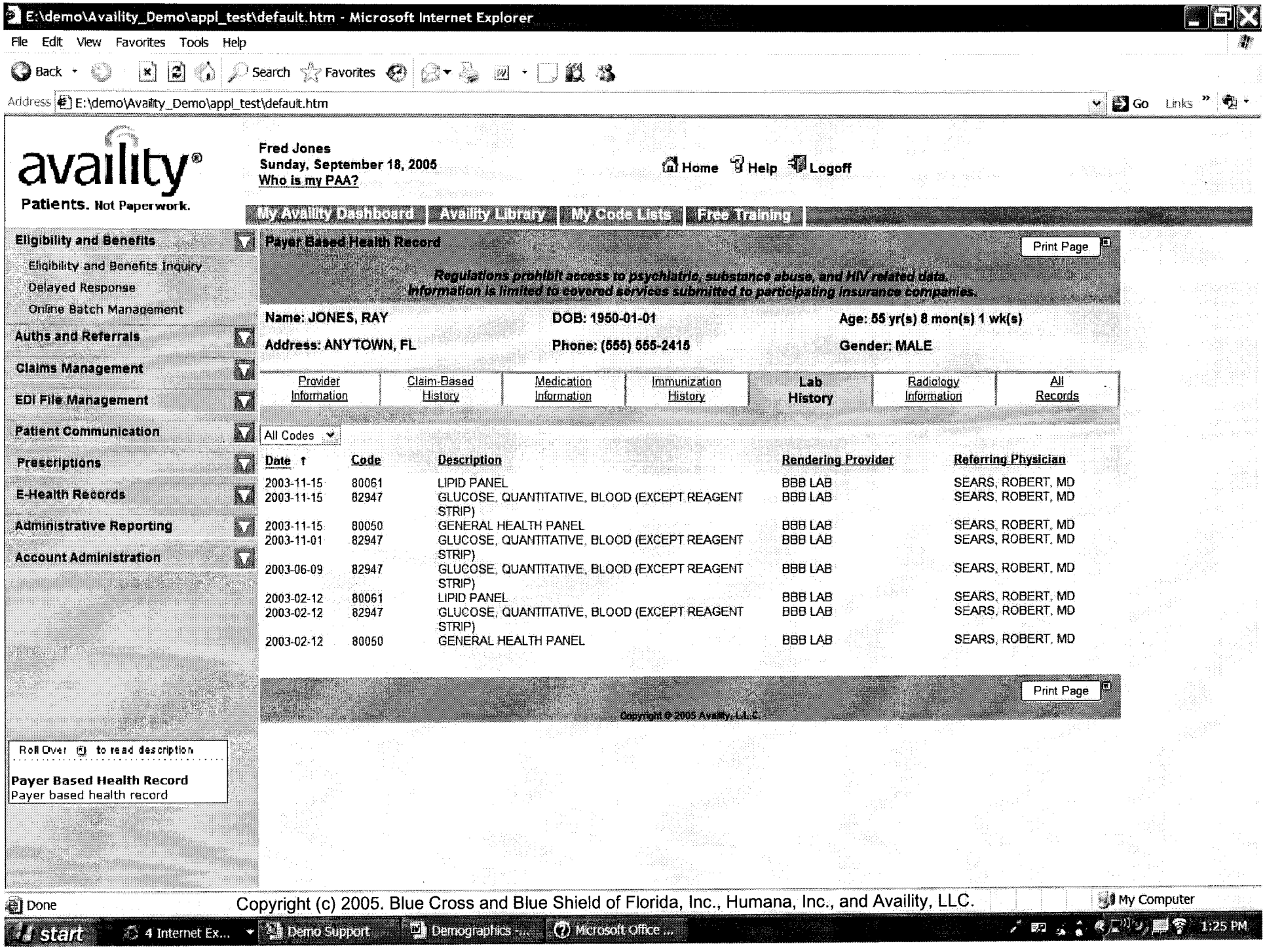

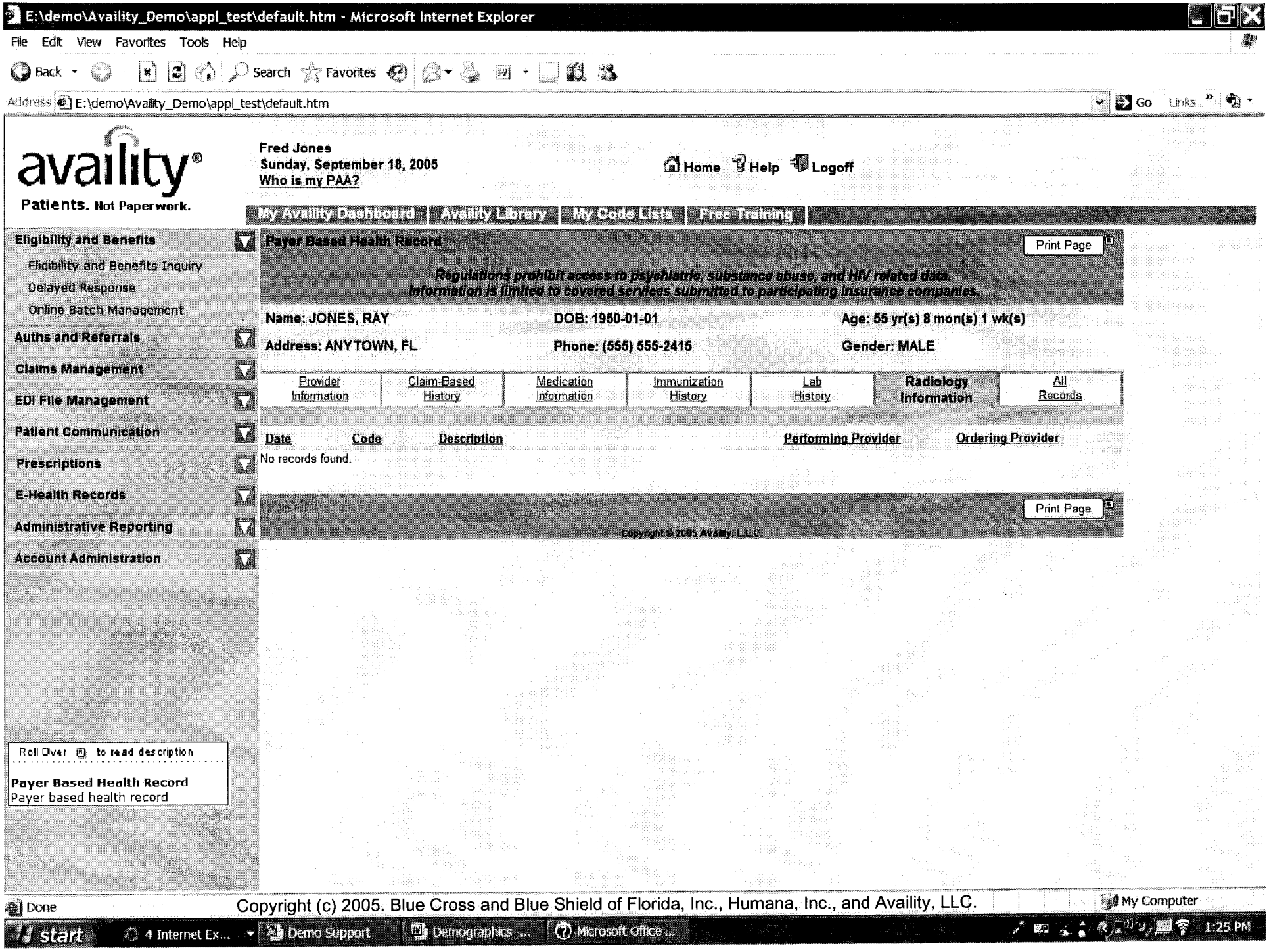
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DOB: 1950-01-01
Age: 55 yr(s) 8 mon(s) 1 wk(s)
Address: ANYTOWN, FL
Phone: (555) 555-2415
Gender: MALE
Provider Information
Claim-Based History
Medication Information
Immunization History
Lab History
Radiology Information
All Records
Date
Code
Description
Performing Provider
Ordering Provider
No records found.
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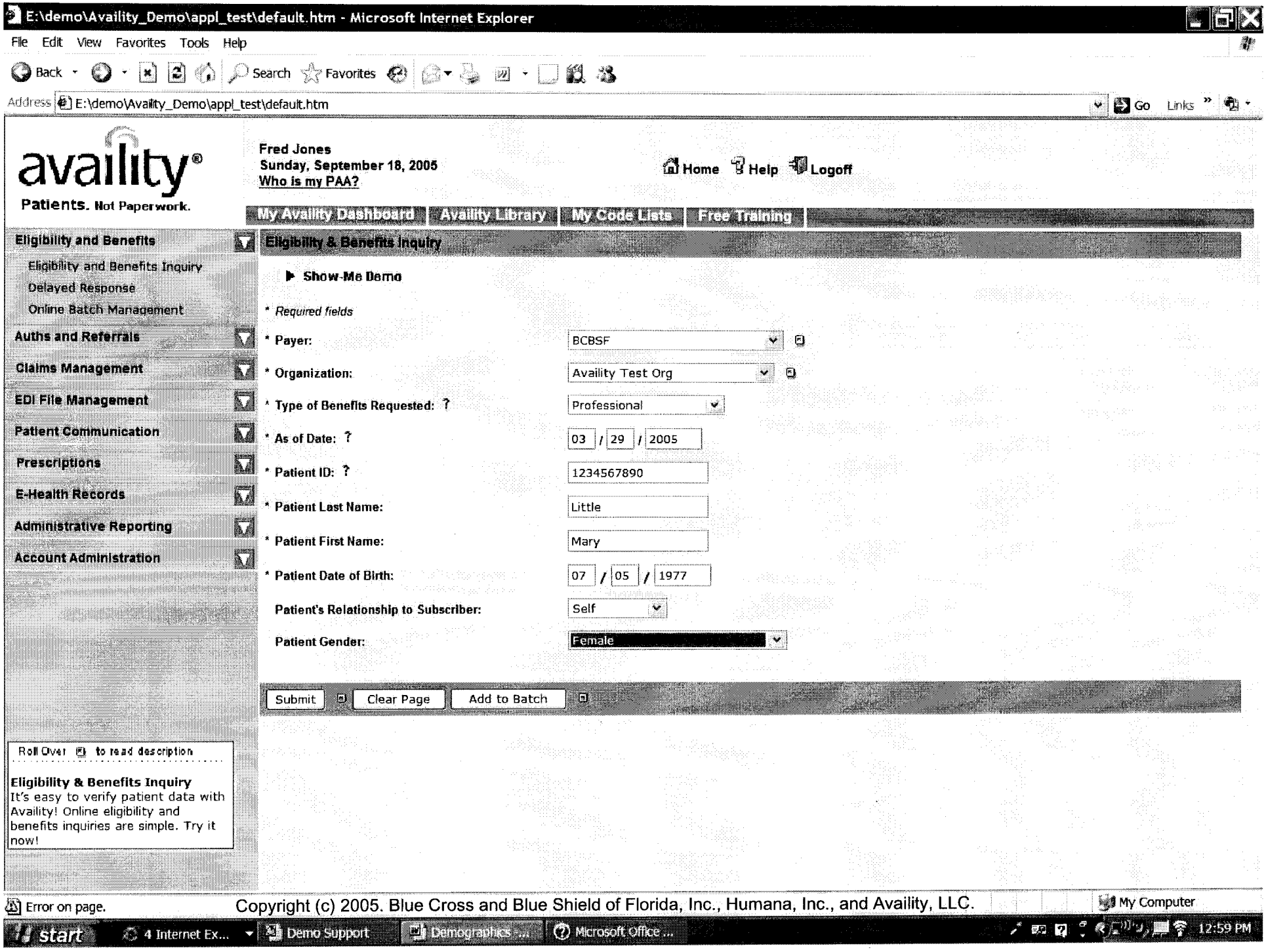
Mary Little

This is a fraud case

- This member is likely to show up in the ER or Urgent Care facility on a weekend with complaint of chronic pain
- She indicates that her personal physicians' office is closed
- The patient has lupus and indicates that she just needs pain medication to make it through the weekend
- This patient has not been seen before by the attending physician – the physician must make a judgment call
- The doctor is able to access the Payer-based Health Record
- The claims based history provides a indication of past diagnosis:
    - Lupus
    - Hand Infection
- The claims based history also indicates that this patient saw many physicians on the same day for the same problem
- The medication page indicates:
    - that multiple prescriptions have been filled on the same day
    - that the medications are controlled substances
    - and many of the prescriptions are from the same physician
- The patient actually stole an Rx pad from a physician

The value of the PBHR in this case is that it resolves the tension that a physician feels without having adequate information about a patient and mitigates the risk of his license being jeopardized.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Show-Me Demo
* Required fields
* Payer: BCBSF
* Organization: Availity Test Org
* Type of Benefits Requested: Professional
* As of Date: 03 / 29 / 2005
* Patient ID: 1234567890
* Patient Last Name: Little
* Patient First Name: Mary
* Patient Date of Birth: 07 / 05 / 1977
Patient's Relationship to Subscriber: Self
Patient Gender: Female
Submit
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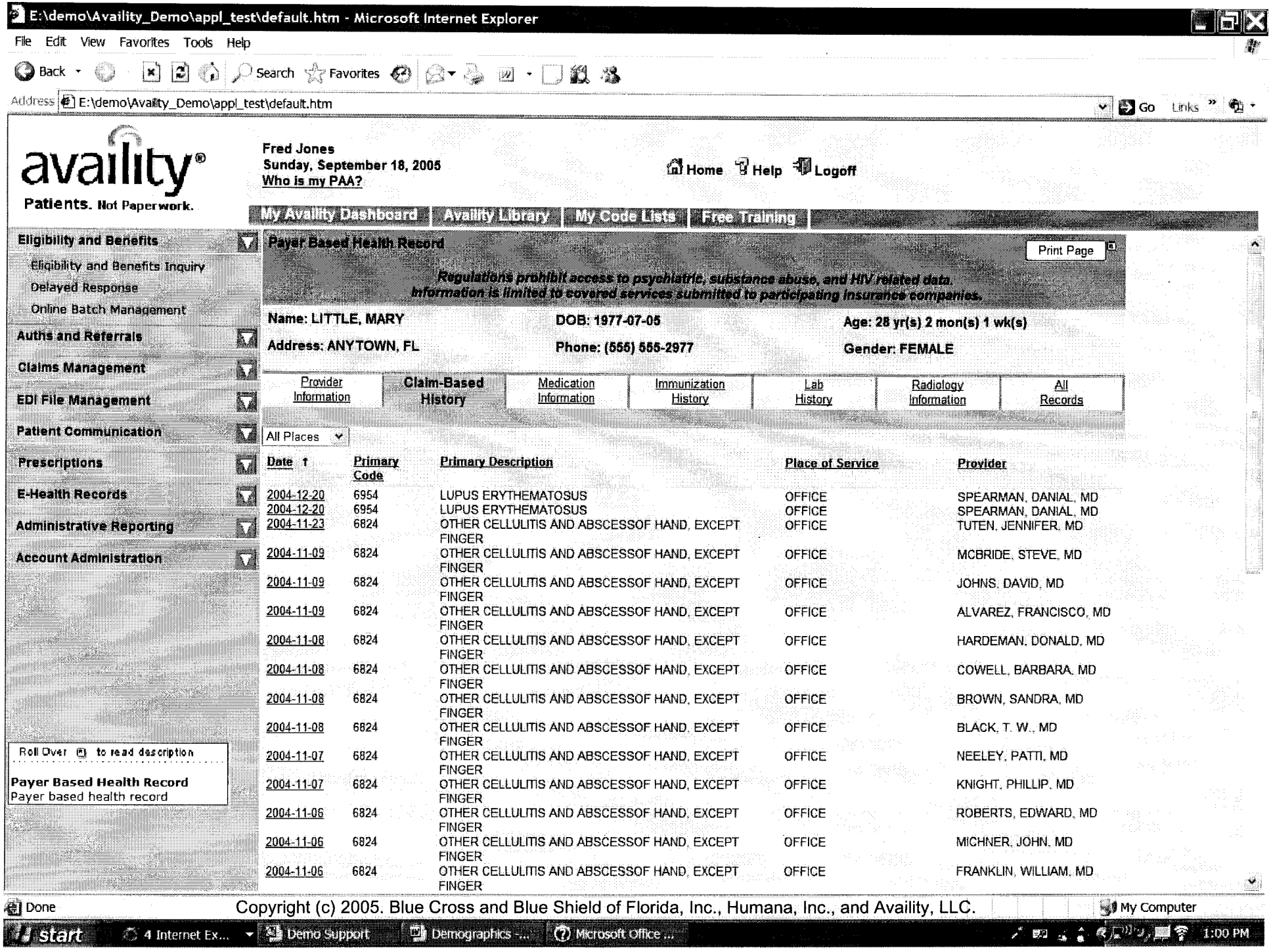

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  - Eligibility and Benefits Inquiry
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Payer Based Health Record
Payer based health record

Payer Based Health Record

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Information is limited to covered services submitted to participating insurance companies.

Name: LITTLE, MARY **DOB: 1977-07-05** **Age: 28 yr(s) 2 mon(s) 1 wk(s)**

Address: ANYTOWN, FL **Phone: (555) 555-2977** **Gender: FEMALE**

Provider Information | Claim-Based History | Medication Information | Immunization History | Lab History | Radiology Information | All Records

Claim-Based Item Detail

Date	2004-12-20
Place of Service	OFFICE
Provider	SPEARMAN, DANIAL, MD

Diagnosis

Diagnosis Code	6954
Diagnosis Description	LUPUS ERYTHEMATOSUS

Procedure

Procedure Code	99212
Procedure Description	OFFICE OR OTHER OUTPATIENT VISIT
Ordering Provider	SPEARMAN, DANIAL, MD
From Date	2004-12-20
To Date	2004-12-20

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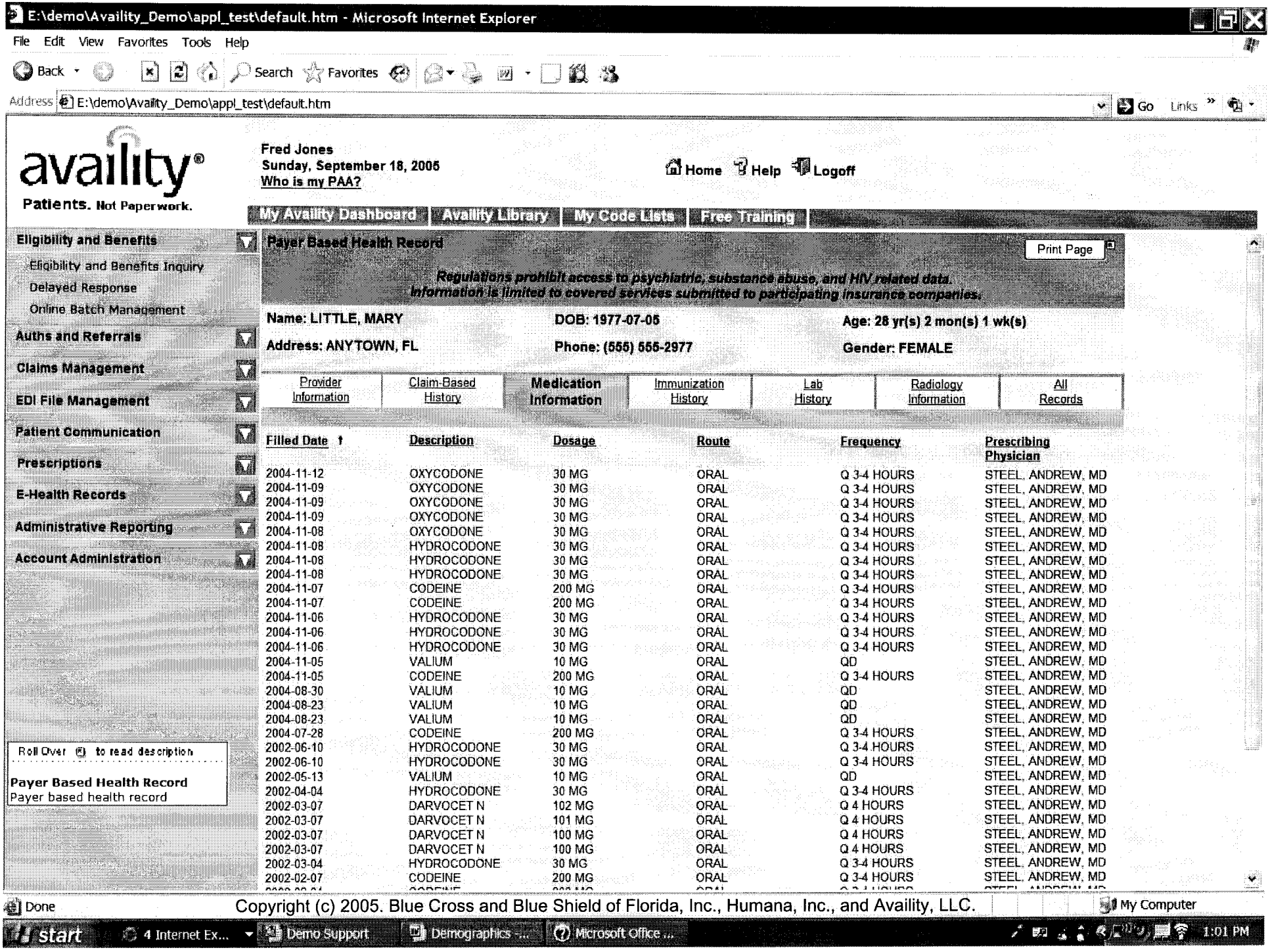
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Claims Management
EDI File Management
Patient Communication
Prescriptions
E-Health Records
Administrative Reporting
Account Administration
Roll Over to read description
Payer Based Health Record
Payer based health record
Payer Based Health Record
Print Page
Regulations prohibit access to psychiatric, substance abuse, and HIV related data.
Information is limited to covered services submitted to participating insurance companies.
Name: LITTLE, MARY
DOB: 1977-07-05
Age: 28 yr(s) 2 mon(s) 1 wk(s)
Address: ANYTOWN, FL
Phone: (555) 555-2977
Gender: FEMALE
Provider Information
Claim-Based History
Medication Information
Immunization History
Lab History
Radiology Information
All Records
Filled Date
Description
Dosage
Route
Frequency
Prescribing Physician
2004-11-12 OXYCODONE 30 MG ORAL Q 3-4 HOURS STEEL, ANDREW, MD
2004-11-09 OXYCODONE 30 MG ORAL Q 3-4 HOURS STEEL, ANDREW, MD
2004-11-09 OXYCODONE 30 MG ORAL Q 3-4 HOURS STEEL, ANDREW, MD
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2004-11-08 OXYCODONE 30 MG ORAL Q 3-4 HOURS STEEL, ANDREW, MD
2004-11-08 HYDROCODONE 30 MG ORAL Q 3-4 HOURS STEEL, ANDREW, MD
2004-11-08 HYDROCODONE 30 MG ORAL Q 3-4 HOURS STEEL, ANDREW, MD
2004-11-08 HYDROCODONE 30 MG ORAL Q 3-4 HOURS STEEL, ANDREW, MD
2004-11-07 CODEINE 200 MG ORAL Q 3-4 HOURS STEEL, ANDREW, MD
2004-11-07 CODEINE 200 MG ORAL Q 3-4 HOURS STEEL, ANDREW, MD
2004-11-06 HYDROCODONE 30 MG ORAL Q 3-4 HOURS STEEL, ANDREW, MD
2004-11-06 HYDROCODONE 30 MG ORAL Q 3-4 HOURS STEEL, ANDREW, MD
2004-11-06 HYDROCODONE 30 MG ORAL Q 3-4 HOURS STEEL, ANDREW, MD
2004-11-05 VALIUM 10 MG ORAL QD STEEL, ANDREW, MD
2004-11-05 CODEINE 200 MG ORAL Q 3-4 HOURS STEEL, ANDREW, MD
2004-08-30 VALIUM 10 MG ORAL QD STEEL, ANDREW, MD
2004-08-23 VALIUM 10 MG ORAL QD STEEL, ANDREW, MD
2004-08-23 VALIUM 10 MG ORAL QD STEEL, ANDREW, MD
2004-07-28 CODEINE 200 MG ORAL Q 3-4 HOURS STEEL, ANDREW, MD
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2002-06-10 HYDROCODONE 30 MG ORAL Q 3-4 HOURS STEEL, ANDREW, MD
2002-05-13 VALIUM 10 MG ORAL QD STEEL, ANDREW, MD
2002-04-04 HYDROCODONE 30 MG ORAL Q 3-4 HOURS STEEL, ANDREW, MD
2002-03-07 DARVOCET N 102 MG ORAL Q 4 HOURS STEEL, ANDREW, MD
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2002-03-07 DARVOCET N 100 MG ORAL Q 4 HOURS STEEL, ANDREW, MD
2002-03-04 HYDROCODONE 30 MG ORAL Q 3-4 HOURS STEEL, ANDREW, MD
2002-02-07 CODEINE 200 MG ORAL Q 3-4 HOURS STEEL, ANDREW, MD
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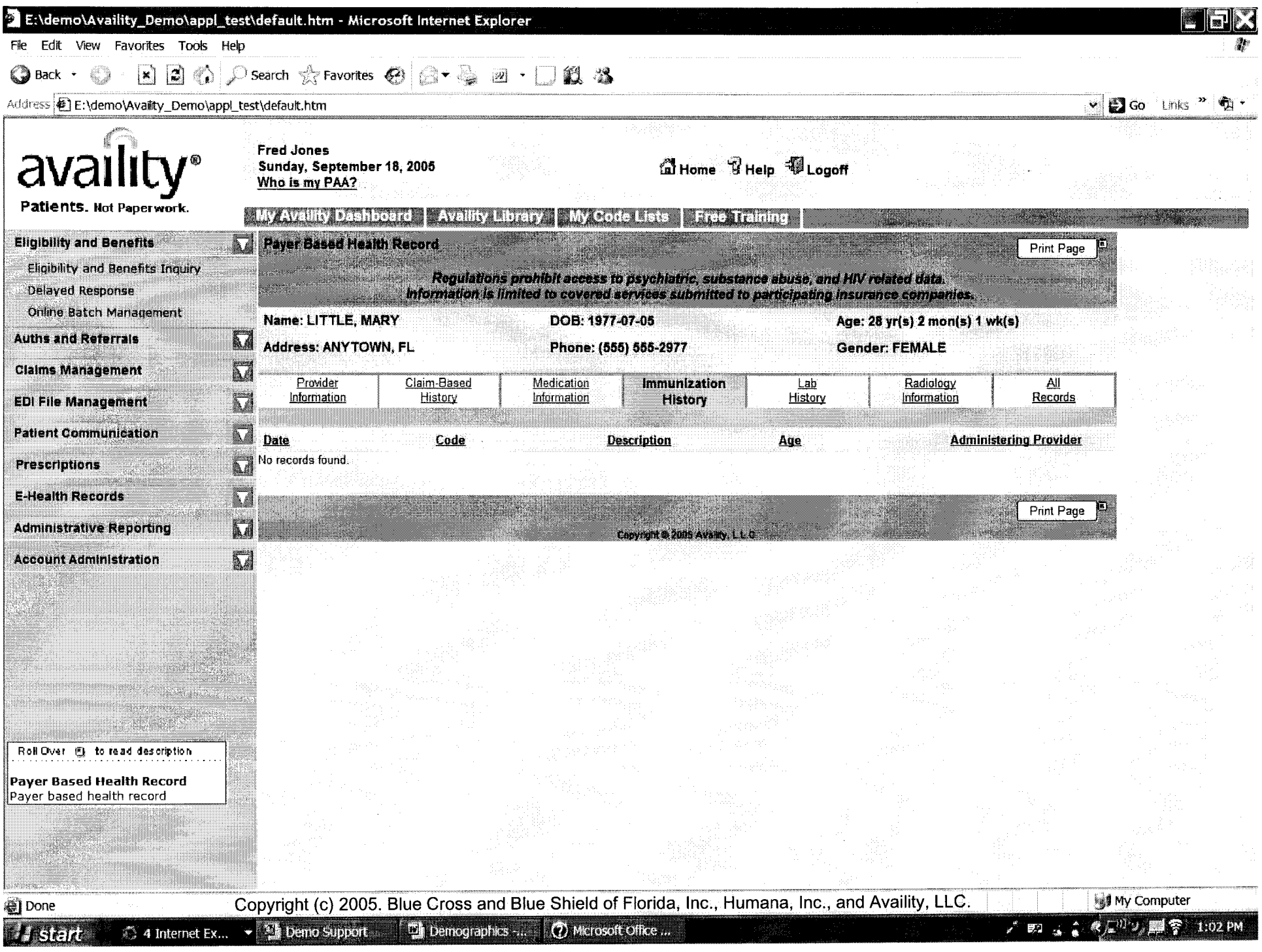
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Patients. Not Paperwork.
Fred Jones
Sunday, September 18, 2005
Who is my PAA?
Home Help Logoff
My Availity Dashboard
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My Code Lists
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Eligibility and Benefits
Eligibility and Benefits Inquiry
Delayed Response
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Immunization History
Lab History
Radiology Information
All Records
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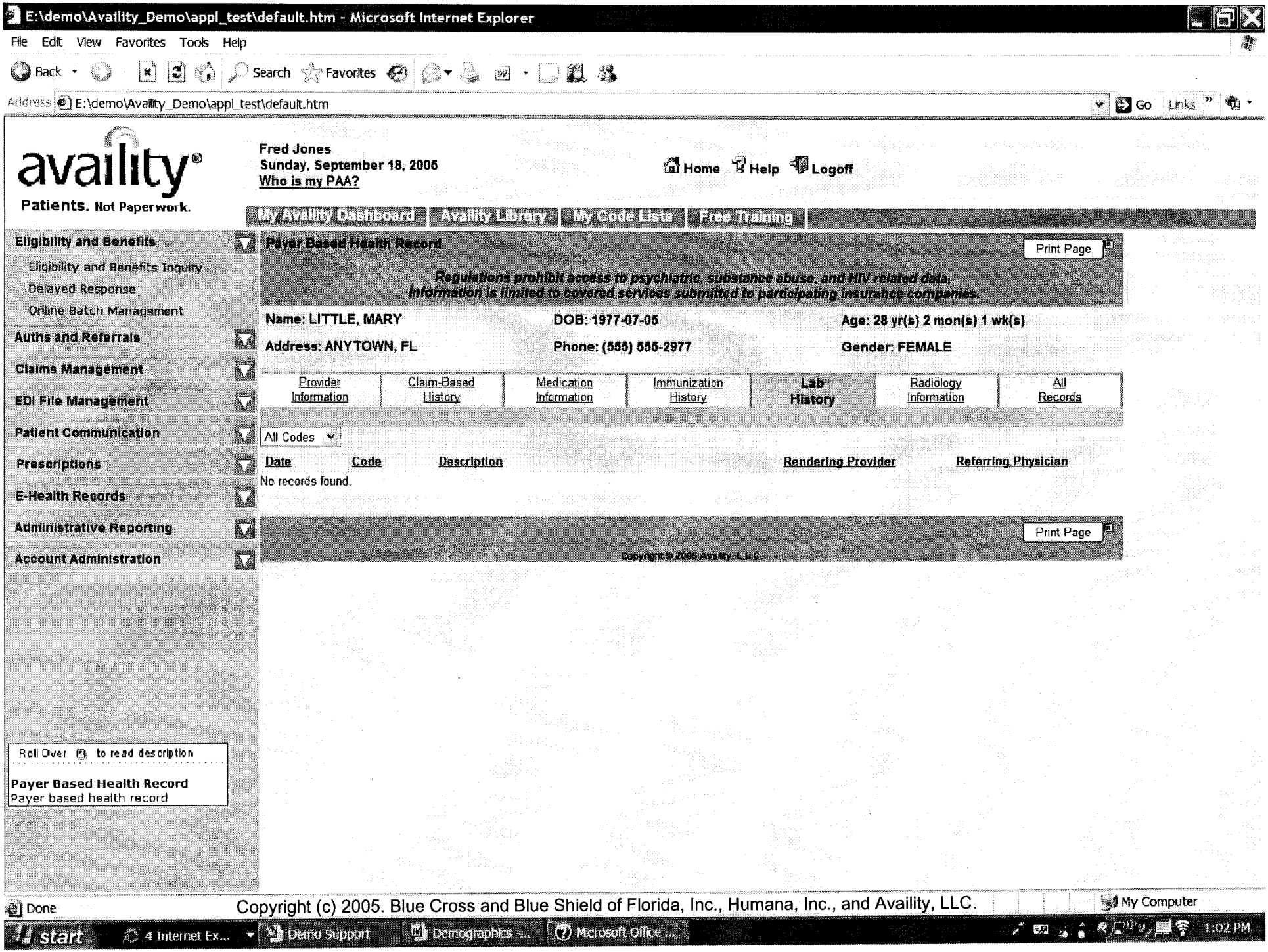
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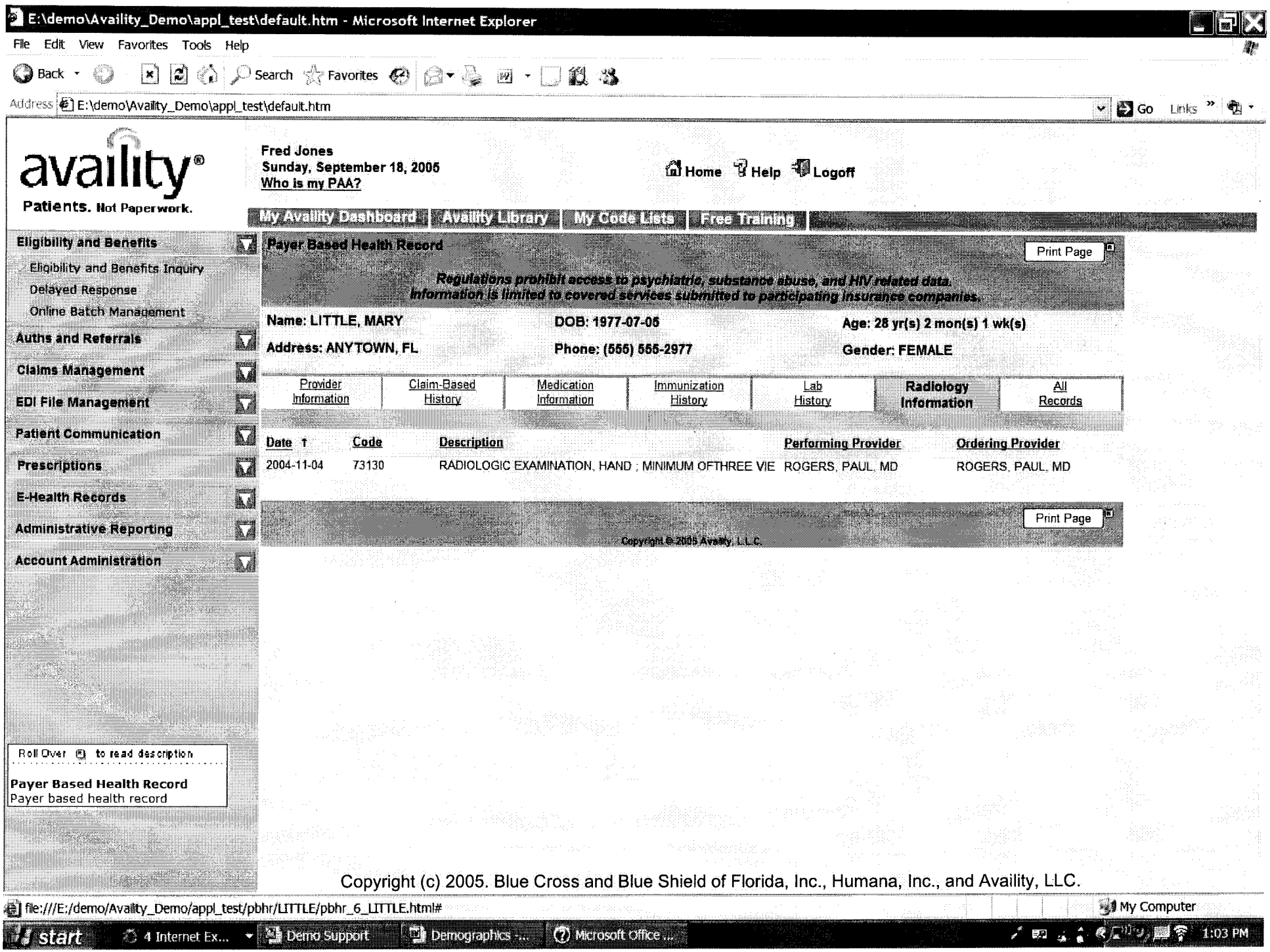
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BlueCross and BlueShield of Florida, Inc.

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- Principal, Navigy Business Development
- Jane.tuten@bcbsfl.com
- 904.363.4834

Humana, Inc.

- Janna Meek
- Director, Innovative Provider Solutions
- Jmeek@humana.com
- 502.681.6050

Presentation
on
Regional Health Information Organizations
(RHIO's)

Carol R. Selvey, MHSA, FHIMSS
Partner, ACS Health Care Solutions

Regional Health Information Organizations (RHIO's)

Presentation to the State of Florida
House of Representatives
Health General Committee

Carol R. Selvey, MHSA, FHIMSS
Partner, ACS Healthcare Solutions
HIMSS Advocacy and Public Policy Committee
November 9, 2005

Overview

- National Action
- Regional Health Information Organizations (RHIO's)
- Florida Initiatives
- Questions

What's Driving Action?

- **Quality**
- **Patient Safety**
- **Excess Costs**
- **Increased Demand**
- **Bio-preparedness**

Paradigm Shift for Healthcare Documentation
Mission: Stop flying blind by …

… adding data-driven guidance

How Healthcare IT Helps

Clinical Decision Support

Potential
ADE Warnings

Clinical
Best
Practices

Critical Lab
Alerts

Protocol
Monitoring

Immunization
Reminders

Alternative
Drugs

Clinical Data
Analysis

Drug/Lab
Monitoring

Wellness
Reminders

Drug/Food
Monitoring

The Value of Interoperability and Electronic Health Records

- **January 2005 CITL Study[1]:**
  - Standardized, encoded, electronic healthcare information exchange would Save the US healthcare system $337B over a 10-year implementation period, and $78B in each year thereafter

- **September 2005 RAND Study[2]:**
  - Widespread adoption and effective use of electronic medical record systems (EMRs) and other health information technology (HIT) improvements
  - Save the US healthcare system $162B annually
  - Potential health and safety benefits could double savings
  - Improve quality and efficiency of the healthcare system.

1. J Walker et. al. *Health Affairs*, January 2005.
2. R Hillestad, et. Al. *Health Affairs*, September/October 2005

HIT Landscape: Everybody Getting Involved

- **Bush Administration FY2006 Budget Request**
  - $125M proposed for utilizing technology to improve healthcare
    - $75M for ONC; $50M for year 3 of AHRQ grants
    - Fully Funded by House; Senate Appropriations funding $95.2M (76%)
- **Executive Branch Changes**
  - Secretary Leavitt creates American Health Information Community (AHIC)
  - Office of the National Coordinator (ONC) office transitions
  - Commission on Systemic Interoperability created
- **Congressional Action**
  - Not partisan issue, therefore champions reaching across party lines
  - 15 bills offered.
  - House 21st Century HC Caucus and Senate HIT Caucus
- **State Houses**
  - Activity in Most states
  - Big Step in Right Direction
  - Not waiting for federal government guidance
  - National Governors Association
  - National Conference of State Legislatures

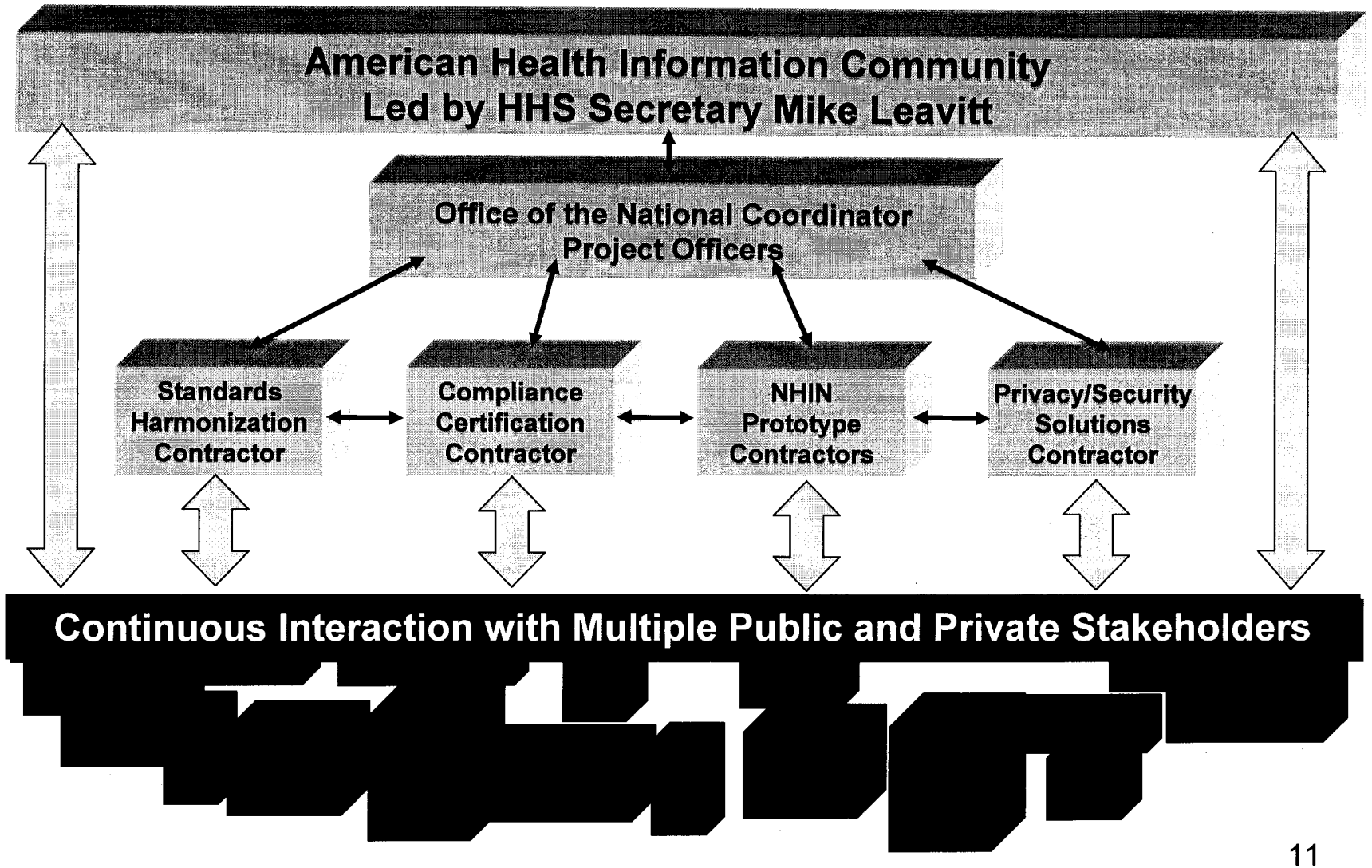
Executive Branch Update

- Department of Health and Human Services
- Secretary Leavitt – Big Proponent of HIT
  - Secretary's 3 Main Initiatives:
    - Impacting a Cultural Change Toward Wellness
    - Realigning the Incentives for Patients, Providers,and Payers
    - Healthcare IT to drive the above
- Current Issues of Interest
  - BioSurveillance and BioPreparedness
  - Medicare Pay-for-Performance pilots
  - Medicare E-Prescribing Proposed Regulations
  - Commission on Systemic Interoperability (October 2005)
  - ONC Organization
  - Hurricane Relief
  - American Health Information Community (AHIC)

Executive Branch Update

- **ONC Organizational Restructure** (August 2005)
  - Formed as ONCHIT in April 2004
  - Federal agencies have the responsibility of turning an executive order into a functioning office.
  - Established KATRINA HEALTH (www.katrinahealth.org)
    - a multi-organization response team addressing legal and technical aspects of evacuee registration/information access, field medical records development and deployment, dissemination and communications, as well as privacy, security and authentication components.
- **4 RFP's associated with AHIC**
  - **Standards Harmonization:** Awarded to ANSI (HIMSS Sub)
  - **Certification of EHR products:** Awarded to CCHIT (HIMSS co-founder)
  - **Privacy and Security:** Awarded to RTI (HIMSS role being considered)
  - **6 Prototypes for a National Health Information Network:** Down-select occurred. Award expected in FY2006

HHS Health IT Strategy



Legislative Branch Update

- **Congressional Organizations**
  - 21st Century Health Care Caucus
  - Senate Steering Committee on Telehealth and Healthcare Informatics
  - Senate Health Care Quality Improvement and Information Technology Caucus

- **Congressional Legislation**
  - 21st Century Health Information Act (Mel Martinez)
  - Health Technology to Enhance Quality Act of 2005 (S. 1262)
  - Health Information Technology Promotion Act of 2005 (H.R. 4157)

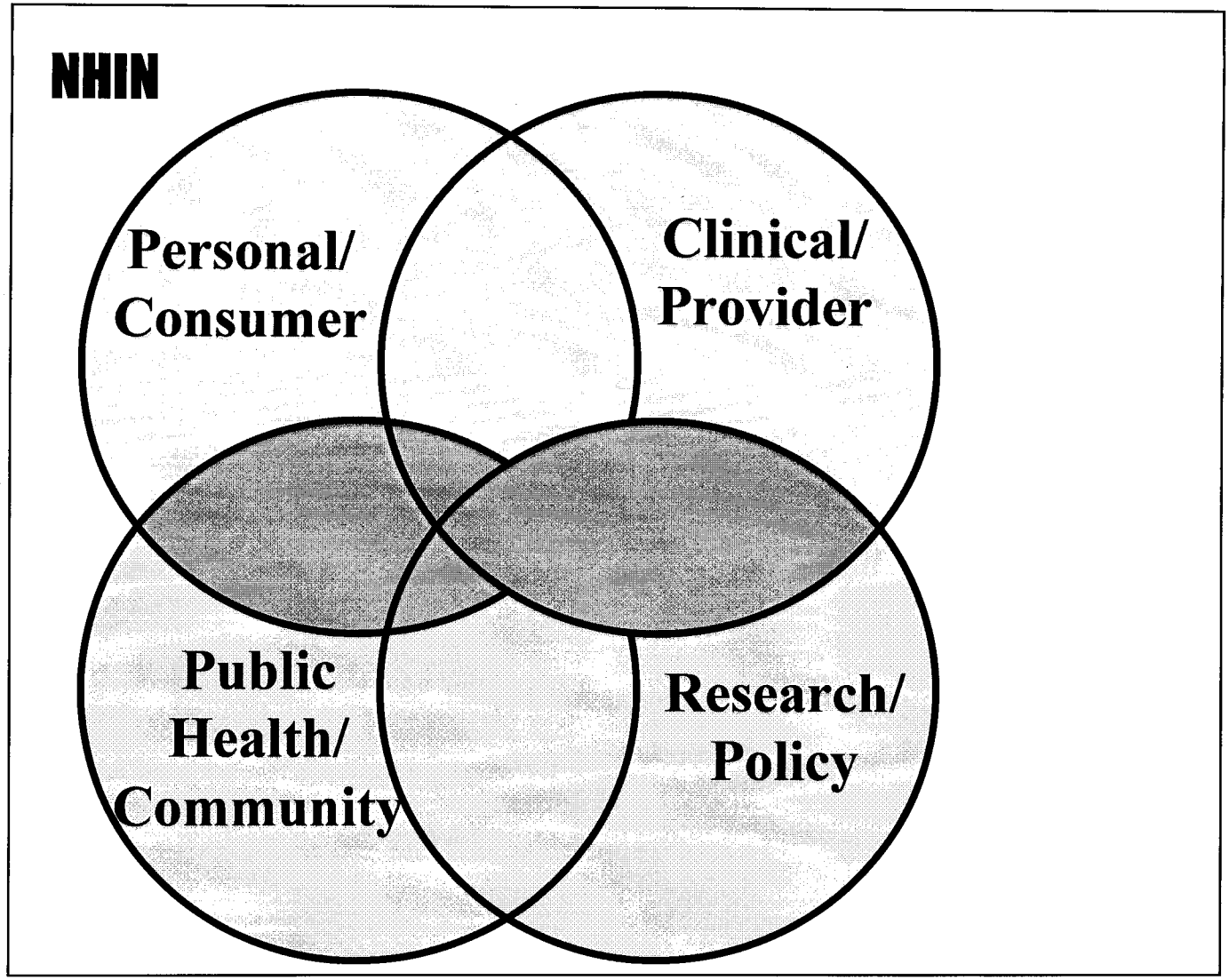
National Health Information Network (NHIN) Vision

- Comprehensive knowledge-based network of interoperable systems
- Providing timely and accurate medical information
- "Anywhere, anytime health care information and decision support"
- NOT a national database of medical records- a national index/mapping of Local Health Information Networks (LHIN's or RHIO's)

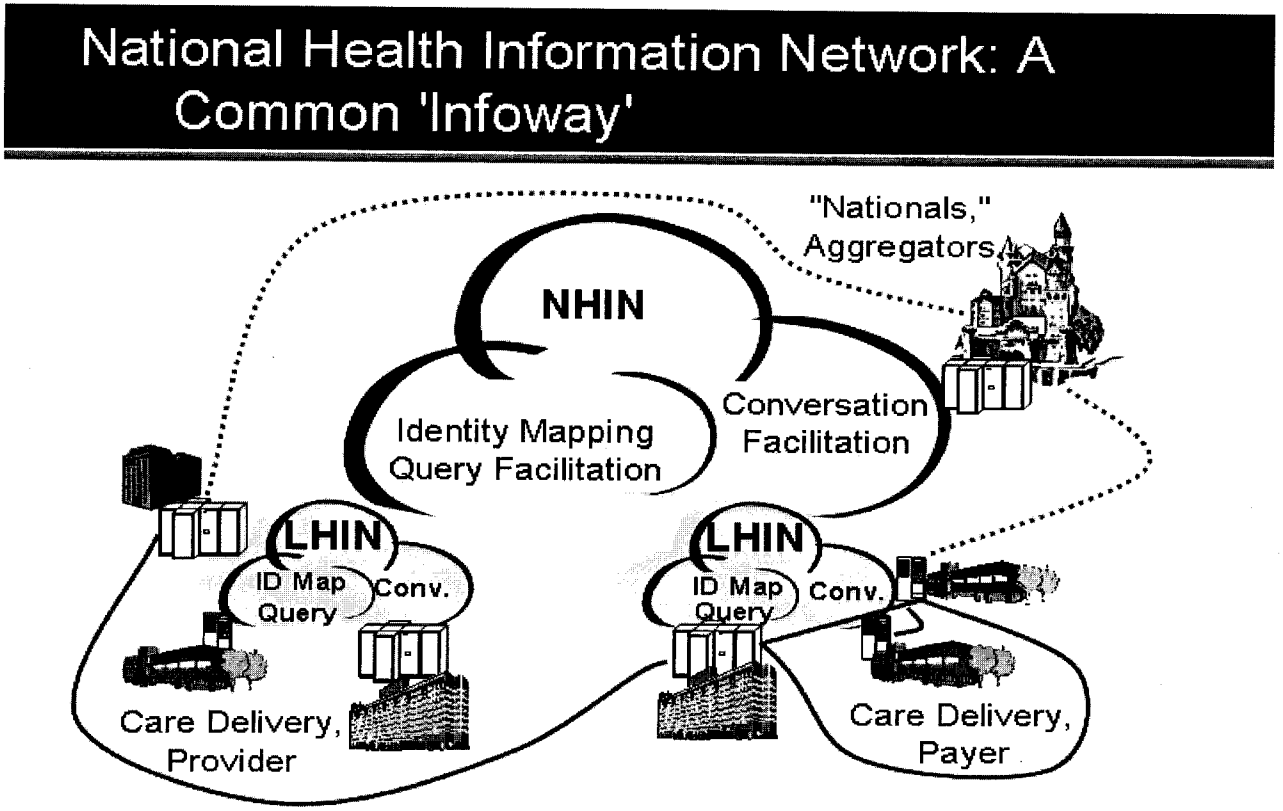
NHIN Vision (continued)

- Systems, Standards, Organizing Principles, Policies and Procedures
  - Organization & governance
  - Alignment of financial incentives
  - Operational policies
  - Message & content standards
- Individual provider Electronic Health Record (EHR) systems are only the building blocks

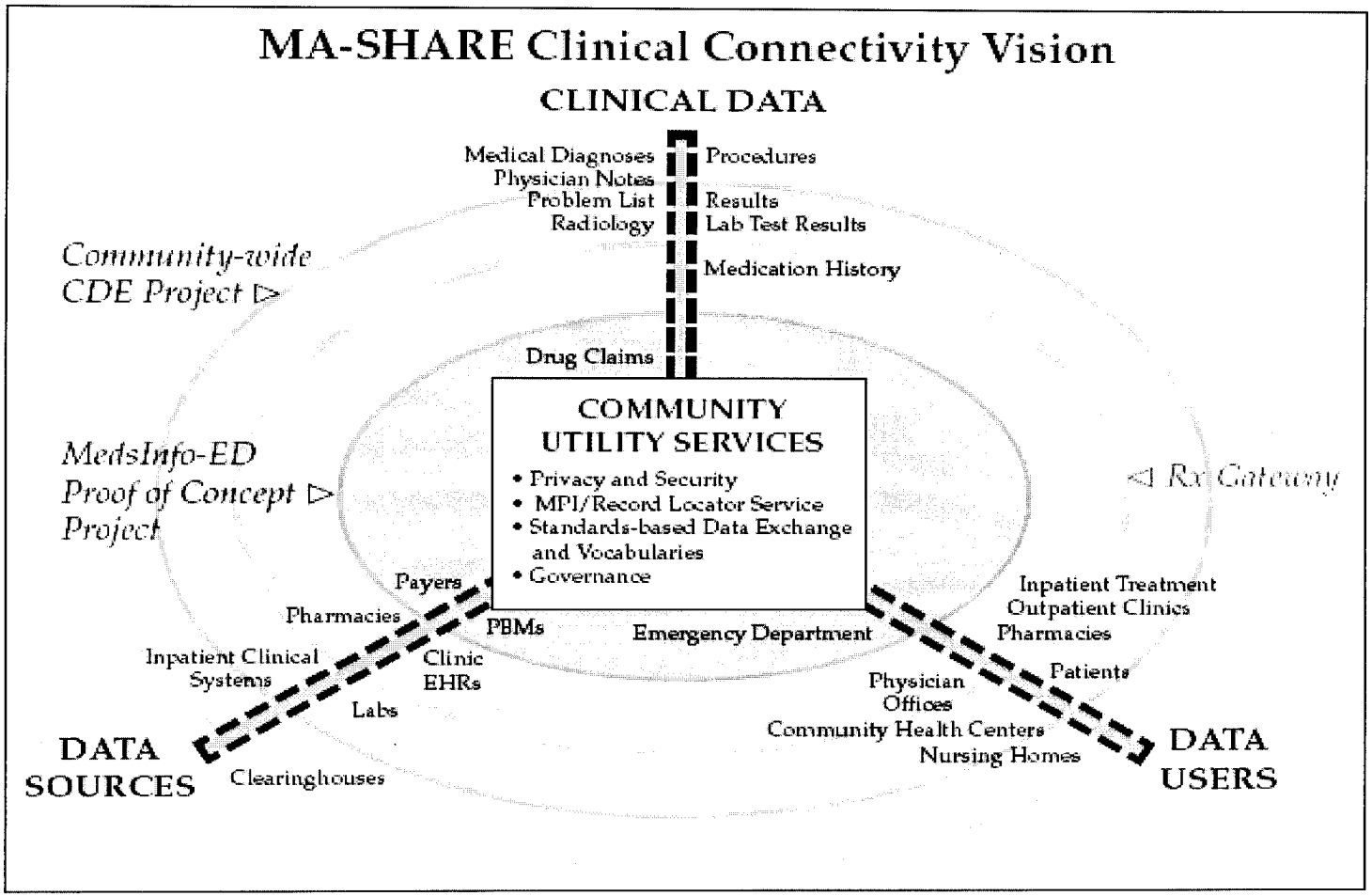
Four Domains for NHIN



NHIN Links LHIN's or RHIO's



Sample RHIO Design



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www.mahealthdata.org

Massachusetts Health Data Consortium

Florida Demonstration Projects

- **Florida's Health Information Infrastructure**
- On May 4, 2004, Governor Bush issued Executive Order Number 04-93
- Creating the Governor's Health Information Infrastructure Advisory Board (GHIIAB).
- GHIIAB established to advise the Agency for Health Care Administration (AHCA) on a strategy for the adoption and use of electronic health records.
- GHIIAB actively seeks to educate through workshops and public forums.
- The First Report to the Governor describes the Board's initial findings and recommendations was presented in March 2005.

Florida Demonstration Projects

- Big Bend RHIO, Tallahassee Memorial HealthCare & Capital Regional Medical Center
- Central Florida Network, Florida Health Care Coalition
- Community Health Record, Jackson Memorial Hospital and the University of Miami
- Diabetes Disease Management, Tampa Bay Partnership

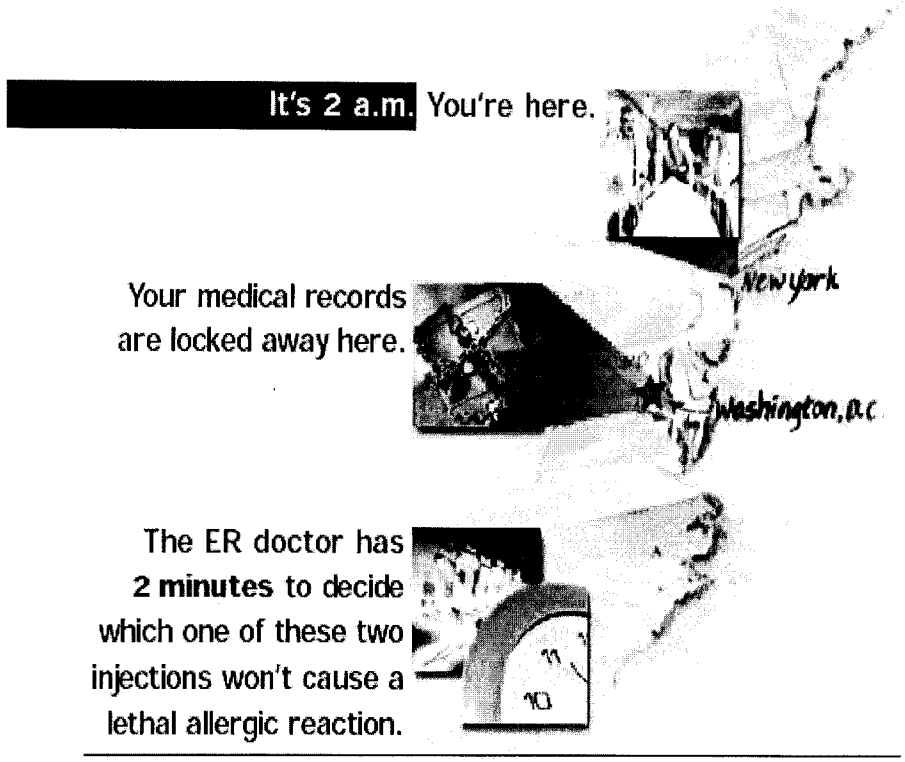
Florida Demonstration Projects

- ER Primary Care Management, Lee Memorial Health Systems & Family Health Centers of SW Florida
- Indigent Health Care Exchange, Good Health Network, Inc.
- Medicaid ePrescribing, Agency for Health Care Administration

Florida Demonstration Projects

- Northwest Florida RHIO, efileshare, LLC
- Pediatric Asthma Personal Health Records, University of South Florida
- Total Cancer Care, H. Lee Moffitt Cancer Center & Research Institute
- Promoting Patient Safety with Web-Based Patient Profiles, Health First, Inc.

Public Information Campaign



Congress should fully fund the President's request for health information technology funding.

We deserve better odds than 50/50.

Dell • eHealth Initiative • Emdeon Corporation
Healthcare Information and Management Systems Society • IBM • Intel Corporation
McKesson Corporation • National Alliance for Health Information Technology
National Association of Chain Drug Stores • SNOMED International
U.S. Chamber of Commerce

AARP • Altarum Institute • American Academy of Family Physicians • American Academy of Pediatrics • American Clinical Laboratory Association

Questions?

Carol R. Selvey
carol.selvey@acs-hcs.com

www.himss.org

http://www.himss.org/advocacy/index.asp

http://capwiz.com/himss/home/

FLORIDA REGIONAL HEALTH INFORMATION NETWORK (RHIO) SUMMARY

Pilot Project	Summary of Project
Big Bend RHIO L. Dan Kaelin, M.D. Physical Address:Vascular Surgery Associates 1405 Centerville Rd., Suite 5000 Tallahassee, FL 32308 Tel: 850-877-8539 Fax: (850) 222-2223 LKaelin@bbrhio.com	This organization consists of 14 major stakeholders which include both hospitals, major providers, payers and a local technology partner. The group was formed to plan, design and implement a health information technology road map for Tallahassee and surrounding communities. The BBRHIO is focused on identifying and rapidly leveraging existing technology opportunities while encouraging and accelerating implementation of new capabilities for the community at large. To date the organization has identified five projects for implementation in 2005. The BBRHIO will follow federal, state and other regional initiatives to align its roadmap with successful outcomes and forthcoming interoperability standards. The road map will evolve but will do so dynamically as to encompass primary and acute care as well as all community stakeholders.
Florida Health Care Coalition - Central Florida Network Richard Schooler 4401 Vineland Road Suite A-10 Orlando, FL 32811 Tel: 407-425-9500 Fax: 407-425-9559 becky@cfhcc.com http://www.flhcc.com/index.cfm	This project is still its planning stage, but its goal is to form a RHIO in Orlando. The Coalition wants to create an electronic health record network among providers and physicians in the Orlando area and push interoperability for health care professionals. The group is drafting a vision statement and preliminary planning document.
Jackson Memorial and U of Miami Medical School - Building the Community Health Record James " Sandy" Phillips JACKSON HEALTH SYSTEM 1611 NW 12th Avenue Miami, Florida 33136 SPhillips@um-jmh.org http://um-jmh.org/default.cfm Huy Nguyen M.D. Chief Executive Officer Cogon Systems Box 13025 Pensacola, FL 32591 850-429-1633 http://www.cogonsystems.com	Phase I of the Community Health Record pilot project will identify and quantify the benefits that Jackson Health System and University of Miami Miller School of Medicine can obtain by leveraging existing information technology infrastructures between a busy Miami outpatient clinic and inpatient and specialty clinics that provide care to an underserved urban population. Two healthcare applications are used in Phase I. Cogon's MOMENT OF CARE™ information system integrates clinical data from existing healthcare information systems and presents clinical data to end-user clinicians via a web portal onto desktop computers or onto mobile devices. Gold Standard Media's eMPOWERx allows physicians to obtain patient medication profile, prescribe medication electronically to accepting pharmacies, and to view drug information. Selected electronic clinical data from different existing information systems will be integrated into the information system. Standard electronic security such as encrypted data and password protection will be employed to protect patient privacy and ensure HIPAA compliance.
Tampa Bay RHIO - Regional Diabetes Management Initiative Russ Thomas Tampa Bay Partnership 4300 W. Cypress Street, Suite 250 Tampa Bay, FL 33607 Tel: 813-878-2208 Fax 813-872-9356 nmealey@tampabay.org	The mission of this project is to develop and implement a health information system which will assist in promoting patient compliance in diabetes care and permit effective coordination of that care and its co-morbidities among the HII Client Parties' healthcare providers. The project will develop a sustainable model for an effective comprehensive health information exchange for the Tampa Bay area that will facilitate the delivery of quality healthcare to the citizens of the area.

FLORIDA REGIONAL HEALTH INFORMATION NETWORK (RHIO) SUMMARY

Pilot Project	Summary of Project
Lee Memorial Hospital Emergency Department and Family Health Centers of SW Florida - ER Primary Care Management Mike Smith Chief Information Officer Lee Memorial Hospital 2776 Cleveland Ave. Ft. Myers, FL 33901 239-332-1111 mike.smith@leememorial.org	This project is in the planning stages. The goal is to guide the uninsured and the indigent to primary care facilities rather than the emergency department at Lee Memorial Hospital. The project will work with Family Health Centers of SW Florida as the primary care facility in Lee County. Implementation of electronic health records will facilitate the passage of patient information between the hospital and the primary care offices.
The Community Foundation of Central Florida and Good Health Network, Inc. - Indigent Health Care Exchange Brian Paige Good Health Network, Inc. 218 Jackson Street Maitland, FL 32751 Tel: 407-629-0304 Fax: 407-539-2784 info@ghnet.us http://www.ghnet.us/	The Community Foundation of Central Florida in collaboration with Good Health Network is developing a standards-based system of Healthcare Information Services that integrates secure network management features into an enterprise-wide business process application. Its goal is to reduce medical costs while giving individuals electronic access to health planning tools to promote improved health. The focus of the demonstration project is to personalize the healthcare management process for patients with chronic illnesses by involving patients in the management of their disease through self-care. The project will assist patients in tracking and monitoring their disease through access to their health data.
Medicaid ePrescribing Mr. Russ Thomas Gold Standard 320 West Kennedy Blvd. Suite 400 Tampa, FL 33606 Phone: (813) 258-4747 Toll Free: (800) 375-0943 Fax: (813) 259-1585 http://www.gsm.com/	Medicaid is now in its second year of its Gold Standard trial program with 3000 total physicians using PDAs that can access real-time patient specific information from the Medicaid fee-for-service pharmacy database (excludes managed care). The application provides drug information, a 100-day complete medication histories of patients, clinical alerts for interactions, therapeutic duplications and allergies, and full electronic prescribing functionality. Gold Standard estimates that its system saved $700 per doctor every month during its first year of the trial.
Northwest Florida RHIO Vinnie Whibbs Efileshare.com, LLC Seville Tower, 4th Floor 226 S. Palafox Street Pensacola, Florida 32502 vinnie.whibbs@efileshare.com www.efileshare.com	In July of 2002, NW Florida hospitals and physician offices began using a secure web-based community network to help streamline the transfer/sharing of patient information between providers. As of May 2005, 100% of the area hospitals, greater than 75% of the physician offices and a variety of independent service providers are now using the secure community based network to process referrals/consults, order outpatient services and send/receive test results. The next step for NW Florida is to formalize it RHIO structure and to extend the network to cover pharmacy & patient communications in the area.
Pediatric Asthma PHR Project Donna Lee Ettel, Ph.D. Lisa Simpson, MB, BCh, MPH, FAAP National Child Health Data Standards Program Director University of South Florida College of Medicine 601 4th Street South, CRI 1008 Saint Petersburg, FL 33701 Tel: 727-553-3660 Fax: 727-553-3666 http://usfpeds.hsc.usf.edu/cri/flichq/home.htm	This project is in the planning stages. The goal of the project is to target pediatric asthma as one indicator of health quality in children. The project is considering a model that relies on electronic health information at the point of clinical service with a provider to track children's health. This information might also be used as personal health records accessible via the Internet for children's parents.

FLORIDA REGIONAL HEALTH INFORMATION NETWORK (RHIO) SUMMARY

Pilot Project	Summary of Project
Total Cancer Care William Dalton, M.D. Moffitt Research Center(MRC) 12902 Magnolia Drive Tampa, Fl 33612 (813) 972-4673 http://www.moffitt.usf.edu/	The goal of this project is to create a delivery system that will integrate new technologies into the standard of care and develop evidence-based guidelines for treatment of cancer throughout the state. The demonstration projects will focus on early diagnosis and prognosis of specific cancers using molecular diagnostic techniques in alliance with statewide affiliates of the Moffitt Center, communities and patients. The project intends to integrate new technologies into standard cancer care, measure health outcomes of patient survival and quality of life, develop evidence based guidelines for cancer care and network information systems for real-time access to guidelines and recommendations. Affiliates in the project will treat about 35-40% of cancer cases in Florida.
Brevard County Health Information Alliance (BCHIA) & He alth First - Promoting Patient Safety with Web Based Patient Profiles Rosemary D. Laird, M.D. Medical Director Cape Canaveral Hospital 701 W. Cocoa Beach Causeway Cocoa Beach, Fl 32931 rosemary.laird@health-first.org Christi Rushnell, MBA, CPHIMS Information Privacy and Security Officer HIT Director of Information Systems Health First Office (321)434-5513 Pager (321)634-0600 Rockledge, FL 32955 christi.rushnell@health-first.org	Supported by grant 1 P20 HS014885-01 from the Agency for Healthcare Research and Quality, Health First Aging Institute; Florida Institute of Technology; and 211 Brevard have worked as collaborative partners to plan and design a health information technology system that is interoperable and can exchange a core set of critical patient information in a standardized usable format between non-affiliated acute care and long term care providers in Brevard County FL. System implementation and evaluation are scheduled to take place in phases over a three year period. System testing and review will be incorporated into each phase to ensure that all components are operational and that safety and security measures for data are in place before patient information is accepted or exchanged. Year one will focus on the technical aspects of building the system architecture and implementing the selected governance infrastructure for the Alliance.

Health Care General Committee

Wednesday, November 9, 2005
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COMMITTEE MEETING PACKET

Revised

ADDENDUM "A" (11/09/2005; 12:30 PM)

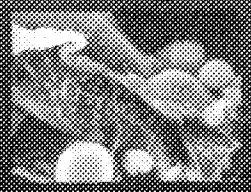
Allan G. Bense
Speaker

Gayle B. Harrell
Chair

Avian Influenza: The Next Pandemic?

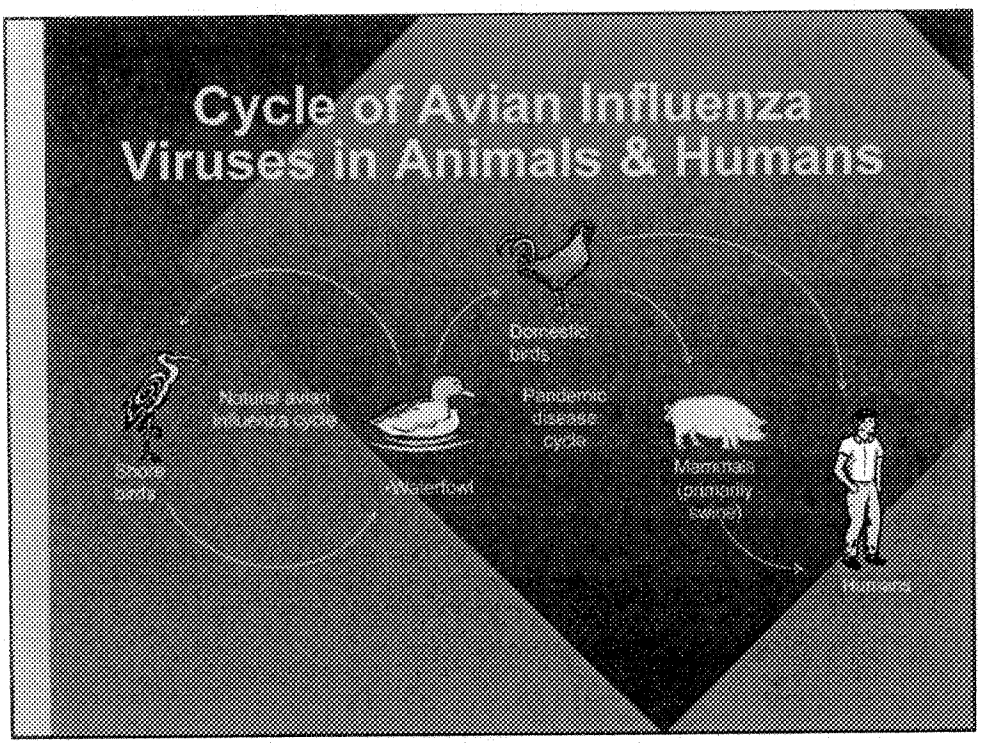
The Florida Department of Health
2005

Structure



- Viral disease
  - Highly infectious type A virus
  - Incubates rapidly
- Comes from wild birds
  - They don't show signs of illness
  - They transmit to domestic animals such as chickens or pigs
- Domestic animals have no natural immunity
  - Potential to transmit to humans through direct contact
  - Humans have no natural immunity

Cycle of Avian Influenza Viruses in Animals & Humans



Epidemiology – Humans (non-pandemic)

- Confirmed Avian Flu in Humans Since 1997
  - 1997 Hong Kong (H5N1)
  - 1999 Hong Kong (H9N2)
  - 2003 Hong Kong (H5N1)
  - 2003 Netherlands (H7N7)
  - 2003 Hong Kong (H9N2)

Affected Countries Avian Flu 2003-2005*

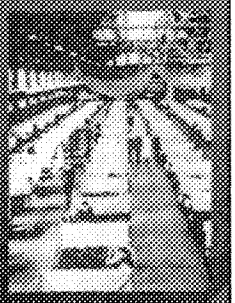
Country	Total Cases
Indonesia	7
Cambodia	4
Thailand	19
Viet Nam	91
Total	121

*As of 10/2005 Source: World Health Organization

Characteristics of Influenza Pandemics

- All influenza viruses can change / mutate
- Spreads between people through airborne droplets or close contact
- Current seasonal flu vaccine not effective against avian flu
- Could be treated with antiviral meds, but resistance to treatment could develop
- Vaccine can take 6 months or more to develop

Historic Pandemics



- 1918-1919 Spanish Flu
  - Type A virus (H1N1)
  - 20-50 million deaths worldwide
  - 500,000 deaths in the United States

Historic Pandemics

- 1957-1958 Asian Flu
  - Type A virus (H2N2)
  - First identified in China Feb 1957
  - Spread to US by June 1957
  - 70,000 deaths in the United States

Historic Pandemics

- 1968-1969 Hong Kong Flu
  - Type A virus (H3N2)
  - First detected in Hong Kong early 1968
  - Spread to US later that year
  - Approx 34,000 deaths in the United States (our seasonal flu kills 36,000)
  - Virus still circulating today

Recent Spread of H5N1

In Birds

- Global surveillance began mid-December 2003
- Spreading -

Cambodia	China	Indonesia	North Korea
Hong Kong	Laos	Japan	Russia
South Korea	Thailand	Vietnam	Europe

Human Involvement

- First identified January 2004 in humans - Vietnam and Thailand
- All originated from close contact with infected birds

Current Status

- CURRENTLY THERE IS NO H5N1 AVIAN FLU IN THE UNITED STATES, IN ANIMALS OR HUMANS.

National Strategy for Pandemic Flu

- Preparedness and Communication
- Surveillance and Detection
- Response and Containment

What is Florida Doing about Avian Flu?

- Monitoring Activities
  - Close communication with Centers for Disease Control and Prevention and the World Health Organization
  - Federal Fish and Wildlife testing wild birds migrating along the Alaskan flyway
  - The Florida Department of Health partners with physicians, hospitals, county health departments, and private labs to monitor spikes in the number of patients seen with flu-like symptoms
  - Department of Agriculture is monitoring poultry flocks closely
  - Monitoring sales of over the counter drugs
  - Increased surveillance at international points of entry by CDC

What is Florida Doing about Avian Flu?

- Response Activities
  - State Comprehensive Emergency Management Plan (CEMP)
  - State Emergency Response Team
  - Emergency Support Functions
    - ESF 8 Health & Medical
  - County Comprehensive Emergency Management Plans
  - County Health Departments

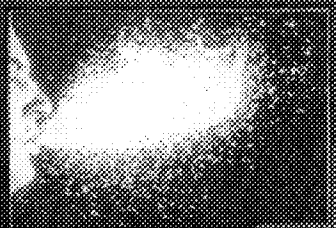
Emergency Support Function 8

The purpose of ESF8 is to:

- Coordinate the State's health and medical resources, capabilities, capacities and response in an "All Hazards" environment during natural or man-made disasters
- Develop an integrated and comprehensive health and medical response system

Flu Symptoms - Humans

- Typical influenza-like symptoms
  - High temp
  - Chills
  - Cough
  - Body aches
- Pneumonia
- Severe respiratory distress



Avoiding Influenza

- Wash hands frequently
- Cover your mouth when you cough or sneeze into the air
- Stay home if flu symptoms appear
- Thoroughly wash eating utensils
- Avoid close contact with other family members

What Should You Do?

- Stay aware and informed
- Practice good hygiene and handwashing
- Continue to get annual flu shot
- Call 850.410.0900 to report clusters of deaths in poultry
- Cooperate with public health directives
- Call 850.245.4401 or your local county health department if you have questions